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NEW YORK STATE

DEPARTMENT OF HEALTH

EMERGENCY MEDICAL SERVICES FOR CHILDREN ADVISORY COMMITTEE MEETING

DATE: January 11, 2022

TIME: 1:00 p.m. to 3:48 p.m.

CHAIR: DR. ARTHUR COOPER

VENUE: WebEx

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APPEARANCES:

BILL LIDDLE
PAMELA FEBER
KATE BUTLER-AZZOPARDI
LINDA EFFEREN
MATHEW HARRIS
DOUGLAS HEXEL
EDWAR CONWAY
ELISON VAN DER JAG
DR. BROOKE LERNER
JOSEPH PATAKY

JASON HAAG
SHARON CHIUMENTO

DR. ALDA OSINGA
BRUE BERRY
AMY JAGARESKI
BRUCE BERRY
JOSE PRINCR
DREW FRIED
DONNA KAHM
BENJAMIN KASP
JENNIFER HAVENS
RYAN GREENBERG
AMY EISENHAUER

JACOB DEMAY
JOHN VAN AUKER

BRIAN LEVINSKY
JAMES DOWNEY

BRIAN WIEDMAN
D'AMBROSIA DENL
MARK DEAVERS
MICHAEL FORNESS
STORM TREANOR
BARBARA CATETTA
LAUREN OREIUOLI
KATE ROSE BULOSE
DAVID SIMMONS
VERA FEVER
VALERIE OZGA

JASON HAAG

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(The meeting commenced at 1:12 p.m.)

SECRETARY EISENHAUER: All right, it looks like we have a quorum now. And everybody that was having trouble with their login are now in. Are you ready to get started Dr. Cooper? Do you want to do the roll call Dr. Cooper?

CHAIRMAN COOPER: Sure.

SECRETARY EISENHAUER: Do you want to share the agenda?

CHAIRMAN COOPER: I'd like to -- go ahead, Amy.

SECRETARY EISENHAUER: Do you want us to share the agenda on the screen?

CHAIRMAN COOPER: Yes, go ahead.

SECRETARY EISENHAUER: Okay. Can you make me the presenter? So this should also be in Boardable for board members, actually.

CHAIRMAN COOPER: While Amy is getting that pulled up, let me just say good afternoon, everyone. We are absolutely delighted to have you all here with us today.

We do have a quorum as Amy just pointed out. And we have a fair amount of business to discuss today and I think a lot of exciting news

and opportunities to bring to the group.

And Amy, are you -- the -- the -- you stated that there is a quorum. Do you need to officially take attendance?

SECRETARY EISENHAUER: I do. I just want to put up this first and then -- there we go. Okay. So this is the -- the Boardable agenda.

CHAIRMAN COOPER: I don't -- I don't see it yet, Amy. Yeah, I don't know if it was there or not.

SECRETARY EISENHAUER: All right.

MR. CONWAY: Yeah, I don't see it either. I have a black screen.

SECRETARY EISENHAUER: Nope. All right. Give me one second. Hold on a moment. How's that?

CHAIRMAN COOPER: There we go. Wonderful. All right. As you can see from the agenda, we have a -- we have a fair amount to cover today. After taking attendance and reviewing minutes, we will hear from Ryan Greenberg, Director of the Bureau.

We'll then hear from Amy Eisenhauer, our -- our incredibly talented E.M.S. program --

E.M.S.C. Program Manager with an update. We're then going to hear it from Peter Dayan and Brooke Lerner regarding a -- an important study that is being conducted by PECARN, and -- and for which Dr. Lerner and Dr. Dayan are seeking our -- our endorsement.

We'll then go through the -- the -- our old business focusing chiefly on the pediatric agitation subcommittee report and the pediatric sepsis subcommittee report. And in addition, we'll have an overview of the Sepsis Initiative from Dr. Alda Osinaga.

Can you -- can you scroll down, please, Amy? And then, we'll get to new business talking about pediatric Covid-19 vaccine, staffing shortages and the discussion of inter-facility transfers within the E.M.S. system and their effect on pediatric outcomes. We'll then hear from our sister committees who are within the Bureau of Emergency Medical Services and Trauma System.

So Amy, would you like to take attendance at this point?

SECRETARY EISENHAUER: Sure. So I'll call the voting members first. We still have some members awaiting vetting. I will call them second.

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Dr. Cooper?

CHAIRMAN COOPER: Dr. Cooper is here.

SECRETARY EISENHAUER: Oh, yes. Also for the court reporter --

THE REPORTER: Yes.

SECRETARY EISENHAUER: -- please state your name for the record.

THE REPORTER: Anthony McClain.

SECRETARY EISENHAUER: Yeah. So Dr. van der Jagt?

CHAIRMAN COOPER: Elise is probably muted.

SECRETARY EISENHAUER: Can you unmute, Dr. van der Jagt?

CHAIRMAN COOPER: Elise van der Jagt. All unmuted.

MR. VAN DER JAGT: I know how to do some of this, so okay.

SECRETARY EISENHAUER: There you go.

MR. VAN DER JAGT: Anyway, thank you. Bye.

SECRETARY EISENHAUER: Dr. van der Jagt?

CHAIRMAN COOPER: I know I heard is

what he said, proof of life.

SECRETARY EISENHAUER: Dr. Albert is going to be absent because he had an emergency in his clinic. Lucretia Bailey? Bruce Berry?

MR. BERRY: Here.

SECRETARY EISENHAUER: Is that a here, Bruce? I didn't hear you.

MR. BERRY: Yes. Bruce here.

SECRETARY EISENHAUER: Excellent. Sharon Chiumento, we are still working on getting her into the meeting and she will be here shortly. Dr. Edward Conway?

MR. CONWAY: Ed Conway is here.

SECRETARY EISENHAUER: Dr. Pamela Feuer?

MS. FEUER: Pamela Feuer is here.

SECRETARY EISENHAUER: Dr. Jose Prince?

MR. PRINCE: Present.

SECRETARY EISENHAUER: Excellent. So currently in the room, we have six of our nine voting members who are vetted and able to vote, so we do have a quorum. And I'll mark those people that come in that are trying to get in.

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So for those of us or those members that can't vote yet, I'll still take their attendance. Dr. Tiffany Bombard? Dr. Vincent Calleo? Dr. Jennifer Havens?

MS. HAVENS: Jennifer Havens is here.

SECRETARY EISENHAUER: All right. Dr. Matthew Harris? I know he was working on trying to log in also.

CHAIRMAN COOPER: He is here, muted.

SECRETARY EISENHAUER: He is here?

CHAIRMAN COOPER: Yes, muted.

SECRETARY EISENHAUER: Okay. Doug Hexel?

MR. HEXEL: I'm here.

SECRETARY EISENHAUER: All right. Chief Pataki? I know he was also trying to get in. Nickol O'Toole?

MR. O'TOOLE: Here.

SECRETARY EISENHAUER: Is that Nickol? Okay.

CHAIRMAN COOPER: Yeah, it looks like it.

SECRETARY EISENHAUER: Ben Kasper?

MR. KASPER: Ben Kasper present.

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SECRETARY EISENHAUER: A little note, so Ben Kasper is from Western New York. And he is undergoing vetting as of a few days ago now. Do you want to introduce yourself very, very briefly?

MR. KASPER: Sure. My name is Ben Kasper and I'm the Injury Prevention Coordinator here at John R. Oishei Children's Hospital for Pediatric Resident Health Center, and I have about a decade of experience working in E.M.S. and working on some safe transport initiatives currently with E.M.S.

SECRETARY EISENHAUER: And he'll be joining as a prehospital provider member. So welcome, Ben. All right. So we have a quorum, and I'll turn it over to you, Dr. Cooper, for approval of minutes.

CHAIRMAN COOPER: Okay. I hope everyone's had an opportunity to review the minutes. Are there any additions, deletions, or corrections to the minutes? Hearing none, I'll entertain a motion for approval.

MR. CONWAY: Approved.

MR. PRINCE: Second.

SECRETARY EISENHAUER: Who are those people that approved and -- and seconded?

MR. CONWAY: Ed Conway approved.

MR. PRINCE: Jose Prince second.

CHAIRMAN COOPER: Thank you, Ed and Jose. Discussion. All in favor, please signify by saying aye.

MR. CONWAY: Aye.

MR. PRINCE: Aye.

MR. O'TOOLE: Aye.

MR. HEXEL: Aye.

CHAIRMAN COOPER: Any opposed? Any abstentions? Okay. Carries -- approval of the minutes carries without abstention. So we now have the honor of hearing from Ryan Greenberg, Director of the Bureau, with that he will tell us as to what's happened since our last meeting. Ryan, please.

MR. GREENBERG: How are you, sir? I will keep it brief. Thank you, everybody, for joining the -- the council meeting today. I know there's a lot going on around the State, including for us.

So just a quick update on -- on where things are. Right now the primary mission going on within the Bureau of E.M.S. is related to around COVID and COVID activity and patient movement, load

balancing, and community support.

We currently have two federal deployments in New York State; one assigned to Upstate and one to New York City that is fulfilling additional assistance to the 911 system as well as load balancing and patient movement of hospitals who don't have capacity and need assistance moving their patients to another location, another facility.

We currently have thirty ambulances, sorry, forty-two ambulances Upstate and fifty ambulances in New York City, so just under a hundred that are working on this mission.

If any of your hospitals or facilities are in need of assistance with patient movement because they can't find a local resource to do it, or they need assistance with even finding a bed for a patient at another facility because of load balancing and your facility E.R.s are holding patients in E.R.s, please feel free to reach out to the CERT operation center and we'd be happy to help you with both of those situations, both in bed matching, as well as the movement of the actual patient.

So that's taking up a lot of our time right now. We have a lot of, you know, good things,

hopefully coming in 2022 if we can, you know, just get past the pandemic a little bit. But E.M.S. for children, and I know, Amy, will report out on that a little bit later on a number of things. There is a really important survey that's opening up for -- that actually is open now, for E.M.S. agencies.

And then you know, we are working a lot with our data and informatics unit in order to get better data -- getting better data, so really excited about in 2022 is also a program that we'll be implementing, which is called Biospatial.

It's an analytic program -- program that -- as it continues to roll out, we'll take the data from E.M.S., put it into one centralized place and then allow us to share that back with our counties and the agencies, and the agencies will be able to see how they're doing in their clinical care compared to other similar sized agencies that they work with.

So when we start looking at pediatric care and care of children, and did they do a set of vitals and so on and so forth. These are all things that we'll be able to look at and kind of move forward. We're really excited to be getting that one

on board in 2022.

Vital Signs was really successful this year, we're quite happy with it being it was the first time we did a hybrid version with having just over five hundred people in person and another nearly three hundred virtually, so we were at about eight hundred participants.

Normally, our -- our participance is about twelve hundred. But super happy with COVID and everything else is actually the numbers we want it to land up to. So really excited about that one next year, it will be October 26th through the 30th in Albany, New York, right, right in Albany.

So please come and join us. It's an excellent pediatric component, and to this group, and as I know many of you are subject matter experts, and I just heard someone talk about safe transport is, you know, the call for presenters is now open.

So if you do have a great topic that you'd like to bring to the E.M.S. community during our annual conference or a C.M.E. conference, please feel free to submit those now. If you don't know where to submit that, please feel free to ask Amy Eisenhauer.

Our E.M.S. Memorial is May 17th. There are nine heroes as of now that are going on to the wall. And we're working on also an expansion with the wall and -- because we've run out of space.

So those are the big things happening there. Happy to take any comments, questions, or concerns. Again, really appreciate that Amy as being here. I may need to drop off in a little bit. I apologize for that one but keep you in the very capable hands of Amy Eisenhauer. Thanks so much.

CHAIRMAN COOPER: Thank you, Ryan. Any questions to Ryan at this point? Well, hearing none, well, thank you, Ryan, again for your -- for your remarks and your update. Amy, let's move on to the E.M.S. For Children grant report.

SECRETARY EISENHAUER: Great, thank you so much, Dr. Cooper. So Ryan did mention a survey and I have a little presentation for you in a moment. We did submit our noncompeting continuation grant request.

And that was at the beginning or middle of December. And pretty much E.M.S.C. federal decided that because of the pandemic, this would have been the time that we submitted the competing grant

for the next five years.

So E.M.S.C. federal because of everything going on, just automatically renewed it for another year for everybody. So we had to submit a budget like every year and then just some documents about the work that we've been doing. And so we submitted all of that to HRSA, and they are currently reviewing it.

Also, I knew that Ryan had mentioned the Vital Signs conference. We did have a PECARN and that has some of our panelists here featured. So Dr. Havens and Chief Pataki and Dr. Calleo came up and did a session on pediatric agitation, mostly discussing the reasons why.

So you know, ACEs and traumas surrounding most of those things. And then, also, Dr. Haven shared with us about de-escalation. And actually, that part of the session ran over, because everybody had so many questions, and -- and were very engaged, which is awesome and refreshing.

And we had fifty-three live attendees, and I believe thirteen virtual attendees for the PECC. The second half of the PECC also included some of our panelists, including Doug Hexel.

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I know Jason Haag is here in the house somewhere. He was there as one of our trainers. Alan Bell from Clifton Park-Halfmoon came and really helped us out. He brought a lot of equipment and different devices with him so that we could do a hands-on skill station for patrons for pediatric patients.

And that was also really well received and we had to kind of push everybody out of the room, they wanted to stay, but it was lunchtime, we had to transfer the room for the next group coming in.

So hopefully next year, we'll do some more of the same. I'm also going to be at several events around the State. ... session, which is on Long Island that's going to be virtual, they just moved this because of Omicron.

They are also having a sponsored call in March and I will be at both of those. I'm also scheduled to be at the Finger Lakes conference. So that would be great.

Hopefully things will slow down by then and we can all join in person. I'm also working with State fire chiefs. They are having an E.M.S. show on Long Island and that's in February. So

pending those things occurring, I will be there talking about E.M.S.C. and PECC, Safe Transport of Pediatric Patients.

Also at Vital Signs, Sharon Chiumento received our lifetime achievement award from E.M.S.C. and that was really great and well received. And I don't know if she is in the meeting yet, but congratulations again, Sharon, thank you so much.

I know that we're going to talk about pediatric COVID vaccines, specifically, five to eleven year old but I also just want to make everybody aware that this morning, and you can go right on the governor's website and find this, the governor is encouraging certain age groups to receive boosters.

So that -- all of the specifics related to that are on the governor's website. And I will put the link in the chat in a bit once things slow down and I can get it in there.

Speaking of vaccines, we are going to have a Vital Signs Academy this coming Tuesday. Dr. Harris, who is on the panel today, he will be doing a Vital Signs Academy course on pediatric vaccines at large with some highlights on COVID vaccines.

So thank you so much, Dr. Harris, for putting that together and coming to give us some education on vaccines in general and then why it's important for kids to have them.

All right. So those are the major items and I will share my presentation on the survey. So much like we have the N.T.R.P. survey recently, every year E.M.S.C. does an E.M.S. agency survey.

All right. Well, are you guys seeing my notes or are you seeing the slides?

CHAIRMAN COOPER: We see your slides and we see the many -- many slides drive on the left. We don't see notes on this first slide, we may see them on subsequent slides.

SECRETARY EISENHAUER: How about now?

CHAIRMAN COOPER: We see a note.

SECRETARY EISENHAUER: Okay.

CHAIRMAN COOPER: We see that.

SECRETARY EISENHAUER: Yeah. That was weird.

CHAIRMAN COOPER: Yeah.

SECRETARY EISENHAUER: All right. Thank God. I'd hate to take the next five minutes and find out but. All right. So every year E.M.S.C.

with NEDARC, which is our data arm in E.M.S.C. puts out a survey, it's a short survey, it takes about ten minutes to complete.

It's really covering performance measures number two and three. Number two is, does your agency have a pediatric emergency care coordinator? And number three is, does your agency do skill stations?

So training with skills included. So they asked those questions. They also ask basic questions about what level agency are you, so certified first responder, B.L.S., or advanced provider, you know, basic things like that.

How many pediatric calls did you do? How many overall calls did you do? So just collecting basic data like that. So that started last week. Thank you so much to the ten percent of agencies who already replied. You will be receiving more emails if you didn't reply throughout the next few months and then ends in March.

So for some reference, this is from last year's survey. And this is -- so NEDARC will break it out as national so this is the national information. So out of almost sixteen thousand

agencies across the United States and several territories, almost seven thousand took the survey. And the agencies responding are emergent responding.

So they say 911 but for example, if you have a college E.M.S squad and they don't use 911 for your campus, but you're responding to emergencies at your campus, you can still be included. And I know that many of our college agencies here in New York State, we have forty-five of them also do mutual aid, so they are included.

So as you can see type of licensures, type of providers, and then times of calls, et cetera. And then this is New York State specific. So the percentages at the bottom, the large numbers, now, those are of the agencies that replied.

So also considering that this was at the top of the major pandemic with a lot of confusion, out of our one thousand five hundred and seventy-eight, we had a twenty-five percent response rate of almost four hundred. And they clean the data so some of that includes, you know, they don't respond to 911, that's one of the questions.

So they excluded, I believe one facility here. So thirty-five percent of those that

responded have a pediatric emergency care coordinator and use pediatric specific equipment and do training on it.

So some of these I put these in here just so you see that we're not just asking questions arbitrarily and putting it in a file somewhere. So for this survey it started last week on the fifth. You can find the survey at emscsurveys.org.

And what somebody would do with that general address is put New York State, find your county, find your agency. And it's important that agencies use their specific agency name because NEDARC compares year to year data occasionally, and the survey ends on March 31st.

And if you forget all of this, you're welcome to email me. I'm happy to share this information with you. Or if you're an agency, I'll send you your specific agency information.

CHAIRMAN COOPER: All right.

SECRETARY EISENHAUER: Do you want me just to roll into the tech update?

CHAIRMAN COOPER: Sure, perfect.

SECRETARY EISENHAUER: Donna and Alicia are still handling this for us. They're doing

awesome jobs. We currently have as of the beginning of this month two hundred and three Pediatric Emergency Care Coordinator agencies with many more techs, so some agencies have more than one, depending on their size and specialty.

Also, Southern Tiers Health Care Services has been having a variety of sessions with Scott Orr(phonetic spelling) from Pediatrics on pediatric emergency care. And that is in place of their conference that unfortunately was also canceled due to COVID.

And we are always looking for more pediatric emergency care coordinators. So if your agency is interested or curious, needs information, they can reach out to Alicia or they can reach out to me, and the website is nyspecc.org.

And we'll be happy to share any information or answer any questions for you. I think that is everything that I have. Does anybody have any questions?

MR. VAN DER JAGT: Yes, Amy, I had a question about the -- the survey from last year. Can you clarify again, is -- did those responses which are three hundred and ninety-four responses out of

like fifteen hundred or so, are those -- are they people responding on behalf of the agency, or are they individuals that are responding?

SECRETARY EISENHAUER: Those are the leaders of the agency.

MR. VAN DER JAGT: Okay. So it's really -- this is representative of what the agencies have within New York State. Is that --

SECRETARY EISENHAUER: Yes.

MR. VAN DER JAGT: -- right? Okay. Which is basically only twenty percent of pediatric equipment and only thirty-five percent have a coordinator?

SECRETARY EISENHAUER: Of those that replied.

MR. VAN DER JAGT: Of those that replied, yes, which is a twenty-five percent response rate. Yeah, okay. Yeah. Okay. Thank you for clarifying that.

SECRETARY EISENHAUER: Welcome. Do you have a question, Dr. Harris? I see your -- your hand icon is raised. All right. I guess not. All right. I will turn it over to you, Dr. Cooper.

CHAIRMAN COOPER: Thank you. So I --

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I -- I -- do not know if Dr. Lerner or Dr. Dayan have joined us yet?

MS. LERNER: I'm on.

SECRETARY EISENHAUER: Oh, there you are.

MS. LERNER: Dr. Lerner is on.

CHAIRMAN COOPER: Yeah, Dr. Lerner is here.

MS. LERNER: Peter is on vacation so he is not going to be able to attend today.

CHAIRMAN COOPER: Okay. So I guess it's just going to be Dr. Lerner. Okay. You can go ahead.

MS. LERNER: Do you share my slides or can I share?

SECRETARY EISENHAUER: You can share them. I gave you the presenter control. So if you look at the bottom, there's a little square box with the arrow pointing up that says share.

MS. LERNER: Yeah. It's -- and it's grayed out. Shoot.

SECRETARY EISENHAUER: Can you make sure that Brooke Lerner has --

THE REPORTER: Yeah, give me a moment.

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SECRETARY EISENHAUER: -- presenter allowance?

THE REPORTER: Yeah, she does.

SECRETARY EISENHAUER: Okay. Yeah, you should have it.

MS. LERNER: I think it might be my settings. It's my system preferences are wrong. Sorry.

SECRETARY EISENHAUER: Oh, that's okay, I can share your --

CHAIRMAN COOPER: Go ahead.

SECRETARY EISENHAUER: -- I can -- I can share the slides. Just give me one second to take back the control. Can you give me back the control, please?

CHAIRMAN COOPER: Uh-huh. You got it.

SECRETARY EISENHAUER: And pull up your slides. E.M.S.C. protocol, correct? E.M.S.C. slides.

MS. LERNER: E.M.S.C. slides, Lerner.

SECRETARY EISENHAUER: I found it.

MS. LERNER: Give me one moment.

SECRETARY EISENHAUER: There we go. How's that?

MS. LERNER: Great. Thank you. And I apologize for having to say change slides because I know that's super annoying to listen to. Anyway, I'm here on behalf of PECARN. Dr. Dayan and I both represent PECARN in New York State.

PECARN is composed of -- of seven grants from HRSA E.M.S.C. office the same that supports the State partnership. And so Peter runs Penn News, which is New York City, Colorado, and Houston and then I run Champ, which is the only E.M.S. focused note of PECARN, which works to bring more E.M.S. research to PECARN.

But this brings together E.M.S. pediatric researchers from across the country to do both in-hospital emergency department and out-of-hospital emergency research.

Next slide. So we are planning to join your call whenever we can, and hopefully help to exchange information from PECARN to your committee as well as to bring information back to PECARN about things that are happening in New York State.

But this map just gives you an idea of the coverage that PECARN has across the country. More specifically, for today, we have been funded for

our first major N.I.H. prehospital research grant, which is called PDOSE.

Next slide. This is really exciting because it is one of the biggest pediatric E.M.S. awards from N.I.H. that has occurred to date. And this study is looking at pediatric dose optimization for seizures in E.M.S.

Next slide. So what we know is that in 2014, some evidence-based seizure guidelines were put out that make the recommendation shown here, key to them were to give I.M. and I.N. or I.N. benzodiazepines as first-line treatment and to skip giving an I.V. early on to try to get those medications in sooner.

But what we found in some of our pilot work through PECARN, next slide, is that some of those recommendations don't necessarily get -- happen in the field.

So that preferred I.M. or I.N. route isn't used as often as we'd like. As well as some issues that we found with correct dosing, that there's a tendency to underdose the benzodiazepines when treating seizure patients.

And so one of the reasons that we

think this happens, next slide, is that we make this a very complicated process in the prehospital system. We expect providers to determine the weight, to calculate a dose, decide on the route, sorry, arrive -- decide on the route, decide on the weight, decide the dose, calculate that out to get to the milliliters to be able to give it.

And these things make -- are both cognitively complicated as well as increase time. The use of length-based tapes can help eliminate with the weight with needing to know the weight, but it's still a complicated process that likely lead to delays.

So the P.D. Dose study, next slide, thinks that we can simplify this by using age-based instead of weight-based dosing. So that all you need to know is the patient's weight and then the doses are standard -- sorry, from a patient's age, and then, the doses are standardized.

Next slide. So the aim of the study is basically to compare the impact of using a standardized age-based dosing compared to conventional weight-based dosing in seizing patients.

So can we -- do we more often have the

seizure stop before the child arrives in the E.D. when we use this age-based dosing scheme as opposed to the weight one. This is an effectiveness aim.

The second aim, next slide, is to ensure that this age-based dosing doesn't result in any safety effects. So to compare the frequency of respiratory failure when you do age-based versus weight-based dosing, so to ensure that this change to age-based dosing is, in fact, safe.

Next slide. So this study was reviewed by PECARN and I showed you in that initial slide, there are eighteen emergency-department-based sites within PECARN, as well as nine funded E.M.S. agency sites, including the Buffalo site.

But then there's also additional sites that have joined as ancillary studies, and so this study will use twenty E.M.S. agencies across the country. All of the medical directors at these agencies have agreed to this protocol.

The physicians within PECARN have all approved this study to go forward and then I think it's also important to note the N.I.H. then reviewed the study using their review committees. The F.D.A. has also reviewed this study and all have approved

for it to move forward.

Next slide. So interestingly, if you're familiar with most studies, the gold standard is to use a randomized clinical trial. Typically, people do randomization at the patient level. But since this study is looking at a change in protocol, it uses what's called a stepped wedge design, where the agencies that join the study are actually what are randomized.

So what will happen is right now we're in that year one planning phase of the study getting all the pieces in place, in May of 2022, the study will start and all of the twenty agencies that are involved will start with their normal or correct protocol and then they'll be randomized to a time point where they would train and then switch over to this age-based dosing scheme that's the study intervention.

And so it creates a randomized study, but that really uses a before and after design to look at the rate of stopping seizures as well as the safety outcomes.

Next slide. And so this is the protocol. This is the study protocol. In the packet

that you received it shows that what we are asking you today is whether you would agree with us changing just in Buffalo, the protocol to incorporate this study.

So you can see the New York State shared protocol update that we made that would only be used at A.M.R. in Buffalo. That essentially follows this protocol where when you get to the dosing for the medication, you would dose it essentially based on age as opposed to calculating out their weight.

Next slide. As you know, most research requires that you get the informed consent of the participant before you start. Obviously, at the point that a child is seizing, it's not possible to get consent.

So this will use the emergency exception from informed consent, which is used to allow for us to do emergency research. We are currently in the process of doing the community consultation that's required, a notification before we were to start the study.

Once a patient is enrolled in the study, we will then notify their legally authorized

representative as soon as feasible to let them know that they were in the trial and to allow them to make a choice to continue to provide data to us or not.

This has been reviewed by I.R.B.s it's using -- what's called a single I.R.B. at the University of Utah, that the University at Buffalo I.R.B. has reviewed it and agreed to -- to basically rely on Utah to make decisions for it.

And again, this was approved by the F.D.A. for the investigational new drug application. There's also a device exception because one of the things we'll be doing will be when patients get to the E.D. is using, what's called a Ceribell to get a rapid response E.E.G. from these patients.

And so that's the gist of this study. I'm happy to answer any questions. This was approved -- I forget, I'm sorry, what the committee is called for New York State to approve just Buffalo changing their protocol, but with a contingent on this group not finding any issues with the study.

SECRETARY EISENHAUER: Yeah. So just for everybody's awareness last week, and I'm sorry, I did not write it down, Dr. Brian -- what's his name, Dr. Lerner?

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MS. LERNER: Clemency. We're called the I.C.R. in Buffalo.

SECRETARY EISENHAUER: I wanted to call him another name and I knew that was not accurate. So Dr. Clemency presented to Medical Standards and then SEMAC and SEMSCO last week during that meeting, and they agreed on allowing A.M.R. Buffalo to participate in the study and just change their protocol if we did not have any issue with it.

And I know that of the voting members, some of you kind of had a background with Dr. Clemency on this. I think two weeks ago at this point, but this is the official component. So if you have questions for Dr. Lerner, now is the time.

MR. CONWAY: Yeah, hi, Conway in New York. So I'm a peds critical care doc and I'm trained in neurocritical care as well. One of the questions I have is with the Ceribell.

My understanding it's not approved for use in kids under some say six, some say two. So does this company have their fingerprints on this study at all? Are they supporting it?

MS. LERNER: Yes.

MR. CONWAY: Okay. Does this play

into the -- the I.R.B. in the approval and things?

MS. LERNER: Correct. So basically, they've given us the Ceribells for free and we're buying the headbands through the grant. This has all been revealed to everyone. So it's -- it's not a hidden fact.

It's approved -- it was approved previously to age five, and then, they're in the process, I'm not sure if it's happened yet down to two. But so this was one of the requirements that the N.I.H. asked us to do just to ensure that for patients that aren't conscious, we have a reading so that we can make sure that our outcome, which is actively seizing on arrival or not, is captured.

So this was actually a request of the N.I.H. that we add something like this. And you're right, there is a company supporting it, but they really don't have any role in the study other than they've allowed us to use the device. And that's why we have the investigational device exemption to be able to use it in the study --

MR. CONWAY: Just another --

MS. LERNER: -- and F.D.A.

MR. CONWAY: Who is going to read it,

because the company will provide E.E.G. like epilepsy --

MS. LERNER: Correct.

MR. CONWAY: -- versus you want pediatric, I mean that's the big issue with these is costs, I think it's like six hundred dollars a headband or something.

MS. LERNER: Correct. And -- and not really a focus of the study other than to help us ensure that the outcome is measured accurately. But basically, what they're doing is the E.E.G. reading gets saved to a cloud and then there's a panel of three neurologists that will read it separate from clinical care.

As you may know, the device has a light and makes a noise. It is up to the clinical site if they want to use that in the care decisions. But they will not get the reading or anything from the study. It just goes up into the cloud and then is reviewed by these neurologists to make sure the outcome is accurate.

MR. CONWAY: I'm sorry. Just one more question. So --

MS. LERNER: That's okay.

MR. CONWAY: -- just looking I mean we all know that the current recommendation first drug is a benzo. So you know, for eons we used Phenytoin as the first drug based on adult data. And then finally, if -- and correct me if I'm incorrect, we PECARN actually went back after all these years and looked at Valium sort of head to head to Lorazepam that most of us chose.

And so there's just so many issues with the pharmacokinetics. Somebody in Status Epilepticus that’s profusing poorly, how well absorbed is an I.M. drug going to be versus a per rectum versus getting a nasal, I'm sure this was all looked through and discussed but I'm just bringing up sort of pragmatic, bedside or the stuff that will be dealt with in the field, I think.

MS. LERNER: Right. So in full disclosure, I'm an epidemiologist, so I won't answer your drug question, but what I can say is this went through all of PECARN's committees and all of their physicians, all the physicians with the F.D.A. and the N.I.H.

And this is based on the best guideline recommendations that were published for

E.M.S. So I think those issues are vetted. I think the other thing to remember is this will have a data safety monitoring board so people will continually be looking at safety for -- for this study.

MR. CONWAY: Okay. Thank you.

MS. LERNER: Thank you.

SECRETARY EISENHAUER: So Dr. Lerner, we also have a question in our chat. What is in the proposal for pediatric patients whose weight falls as outliers, and also what protection for the pediatric patients who fall under the O.P.W.D.D. umbrella?

MS. LERNER: Can someone help me with O.P.W.D.D.?

SECRETARY EISENHAUER: I don't know.

MS. FEUER: Office for Persons with Developmental Disabilities.

SECRETARY EISENHAUER: Thank you.

MS. LERNER: Thank you. I'm sorry. I should know that. So -- so there is a criteria within the protocol that says if people look small -- too small or large for their age, that has directions for -- for those situations that it goes back to weight-base. So it is accounted for in the training and in the protocol.

MS. FEUER: Can I ask a question, Amy?

SECRETARY EISENHAUER: Any -- sure. Yes, Dr. Feuer.

MS. FEUER: Hi, Pamela Feuer. Just a couple of questions. And since it's I.M. versus intranasal, what are -- what makes that decision tree? Are there specific parameters that allow that or is that up to the operator at the time?

MS. LERNER: Yeah, that's up to the operator and up to local. So they would choose I.M. or I.N. based on the decision and the situation.

MS. FEUER: And is there a plan to get a standardized intranasal atomizer to every one of these agencies so that it's delivered the same way? Most I.M. shots are -- are kind of the same, you know, a needle in -- in a --

MS. LERNER: Right.

MS. FEUER: -- muscle, but the atomizers are different.

MS. LERNER: Uh-huh. Right. So I don't believe they standardize that across the study but it is within -- so again, this only applies in New York State to A.M.R. Buffalo so they would use the atomizers that they have.

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MS. FEUER: Okay. Thank you.

MS. LERNER: But I will bring that up because it's probably a good thing for him to keep track of for the study.

MR. GREENBERG: Dr. Lerner, this is Ryan Greenberg. So two quick questions for you. One, and -- and I apologize if I missed it when you're talking about it, but my son who is five and wears, you know, size eight or nine clothing.

He is a significantly larger, both height and every way than -- than, you know, a typical five-year-old. How does this adjust to situations like that whether it be on the provider or not the provider is there exclusions? Are they all still treated as a five-year-old regardless of that and how is it handled?

MS. LERNER: Yes, so significant outliers are addressed in the protocol. I can't find it this second, but it gives them guidance for what to do if they seem out of the norm for the age-based -- for their age.

MR. GREENBERG: Perfect, thank you.

MS. LERNER: Uh-huh.

MR. VAN DER JAGT: Brooke, I just like

to speak in support of the study, because -- or the -- because it is the study. One, it's been well-vetted, I think across the country, but I also think that what strikes me is the -- the problems that we currently have of inadequate dosing for Status Epilepticus and the recognition in the last five years that the faster we get Status Epilepticus under control, the better it is and so that the -- I think I saw in there that the underdosing, that's often the case, is -- is a big issue.

And so I think a study that's done under these very -- should we say very diligent and very carefully thought through parameters including a data -- data safety monitoring board, that kind of thing, I think has a lot of merit to do this in one area of New York State because it brings new information to the table about the use of nasal and infused used in this particular way.

The other thing is -- that I want to say is that -- as I'm thinking through that hearing is about -- the concerns about, you know, obesity patients versus no obese patients.

Currently, I think most people would go with the length-based tapes. But now, it's only

very recently that the length-based tapes have adjusted for weight, as well but it's not purely just the length because of our obesity epidemic, which is now at least twenty or twenty-five percent of the population.

The length-based tape is also not as accurate as we once thought it was. So having an age-based, maybe this is a better way to do it. I -- I don't know the answer to that but we -- because all I'm saying is that we struggle on both sides of that length-based tape, which is indirectly weight-based, but it's actually not because it doesn't account for obesity.

And now we have an age-based. We've always fought against age-based for pediatrics, because of all the various lengths and whatnot, and weights. But I'm not sure that one is better than the other and this study at least has the opportunity, I think, to see whether this makes a difference in terms of outcomes of the rapidity of stopping the Status Epilepticus, that's just my thought.

MS. LERNER: Thank you. Yeah, I agree with that. I mean, I think our pilot work showed

that you know, we are underdosing children and the children still come seizing and -- and that's the point of the study, right, to see if we can make this change and get children drugs faster and better and have more children stops seizing using this methodology.

So I -- I think you're right that is the point of studying it.

SECRETARY EISENHAUER: Anybody else? Any questions or comments for Dr. Lerner? Thank you so much, Dr. Lerner.

MS. LERNER: Thank you for your time.

SECRETARY EISENHAUER: So Dr. --

CHAIRMAN COOPER: That being, hearing none, I think Dr. van der Jagt put forward a motion that we endorse this project. Is there a second to that?

MS. FEUER: I second.

CHAIRMAN COOPER: Pamela Feuer, second. Thank you, Pamela.

MS. FEUER: Pamela Feuer. Uh-huh.

SECRETARY EISENHAUER: Who was the initial motion by?

CHAIRMAN COOPER: Dr. van der Jagt, I

believe.

MR. VAN DER JAGT: Yes, -- yes, I strongly support this as a -- a new way of doing it and it's in a very limited capacity under a tremendous amount of scrutiny since it's the study that's done in this way.

CHAIRMAN COOPER: So it's been moved and seconded that we endorse this project. Is there any further discussion? Hearing none, please signify by saying aye.

MR. VAN DER JAGT: Aye.

MS. FEUER: Aye.

MR. CONWAY: Aye.

MR. GREENBERG: Aye.

CHAIRMAN COOPER: Oppose? Abstention? Hearing none, the motion passes without abstention. Thank you.

SECRETARY EISENHAUER: Thank you.

CHAIRMAN COOPER: Thank you, Brooke, very -- very much.

MS. LERNER: Thank you.

CHAIRMAN COOPER: Okay. So we now move on to -- to old business. And the first item of old business is to discuss where we are with our

pediatric agitation workgroup. And I'm going to ask Dr. van der Jagt if he would take the lead on this. Elise?

MR. VAN DER JAGT: Sure. So we had a -- give me just one second here, I got to pull post something up on my screen here. So we had a small group, an agitation subgroup that was put together to discuss the crisis that we are currently seeing across the country with behavioral emergencies.

And there were a number of us -- us on that group including Dr. Vera Feuer, who is a psychiatrist, Dr. Jennifer Havens, psychiatrist, Dr. Pam Feuer, Jason Haag, Dr. Cooper, myself, I'm missing a few people probably.

MR. BERRY: And I was part of that group.

MR. VAN DER JAGT: Dr. -- Dr. Bruce Berry, I think was on there, right? Anyway, so we've met a number of times and we ended up looking particularly at the E.M.S. provider and how they would interface with behavioral emergencies.

So we spent a -- a -- a long -- a large amount of time discussing what would be -- be brought to the table in terms of management of these

behavioral emergencies that is for an agitated pediatric patient.

And in doing that Dr. Havens and Dr. Vera Feuer especially, had been very involved in developing consensus -- consensus guidelines on this, basically what's called the beta guideline for the emergency management of agitated children and adolescents.

And so a large part of our discussions were how do we take this -- this -- these guidelines -- these consensus guidelines, and bring it not only to the E.D., but in particular to the E.M.S. providers.

So then, after a number of meetings, we then pulled the A.L.S. collaborative protocols on P.S.P. 3.4.1 behavioral emergencies for agitated patients. And maybe, Amy I'm wondering if you could put that up there so that everyone can kind of get a sense for this.

And so what I'm going to present is some suggestions for altering this -- this protocol. Obviously, this is a very, you know, preliminary process because we would have to look at it, we would have -- it's -- this is I think, for discussion

primarily, Dr. Cooper. Is that correct?

CHAIRMAN COOPER: That is correct and we're -- we're going to -- to get the input of the committee to --

MR. VAN DER JAGT: Right.

CHAIRMAN COOPER: -- propose some potential changes to the -- to the -- this -- this protocol, which we would then presumably approve at our next meeting. And then, that information will be forwarded to SEMAC for presumably their approval at their -- at their meeting which we plan to follow our own.

MR. VAN DER JAGT: Uh-huh. Correct. Right. So -- so if you see this -- if you can stick with that first section there, Amy, the C.F.R. and all provider levels. We really felt that there needed to be something a bit more specific to these -- these -- this -- this area.

And I am going to be suggesting a couple of things for discussion a number of things for discussion. I'm reading a little bit from my own crib sheet on this so -- so that you'll know exactly what it is but this is from the committee.

So then, for example, I'm just going

to go through this and read some of these ideas that we are trying to put into this. So the first bullet point, which is a call for law enforcement, we will just add as deemed appropriate, because we know that there is a judgment that has to be made there.

We also, by the way, we took the term 'police' which you'll see in the lower parts of this, and we made it just one term law enforcement because there are some potentially negative or positive connotations with police and so we felt that that was a better term.

But then especially under verbal de-escalation, where it says utilize interpersonal communication skills, we really felt that starting in that area, there needed to be more specific guidance to this and we did discuss a lot, you know, what should be in training versus what should be in the protocol and gave it a lot of thought.

But we did feel that it was a very specific thing so for -- and I'm going to read again some of these to you for your consideration. I'm sorry, I don't have the document to put in front of you, but just a consideration because it is a discussion -- open discussion point. So that under

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verbal de-escalation --

MR. VAN DER JAGT: -- say by one person, others keep quiet and then ask the caregiver and/or the child/youth about very specific things, specific event that might have triggered the agitation, usual ways to calm the patient and ask for his or her assistance as appropriate, psychiatric or developmental, behavioral autism kind of diagnoses, medications that usually help or worsen the patient's behavior.

And then, we did look at three boxes that were in the consensus guidelines, which we thought we would add under key points at the bottom but they really relate to behavioral and environmental techniques that might be used. And we thought that it would be helpful to put those under key points in the protocol.

We added that keep the caregiver with the patient, if this has a calming effect, when knowing very well that sometimes it has the opposite effect. Keep the patient comfortable, warm with avoidance of triggers of agitation, and only after all those very specific guidance, it's almost like a checklist, you know, are done, should there be a

consideration of restraints. We know that that is -- restraints can be -- can be very difficult, but we also know that at times they are necessary.

And if the patient ends up being in law enforcement custody and/or is handcuffs, then it's clear the law enforcement officers should accompany the patient to the ambulance, to the hospital but they -- the E.M.S. has -- has to be able to immediately remove any of these restrictions for taking care of the patient.

And then, the patient, again, has -- can you move that down a little bit, Amy, where it says E.M.T. advanced, a little bit beyond that, yeah, under this paramedic, right there.

So as we -- the patient must not be transported in a face down position, which is basically coming up from the -- from under the key points of consideration. The other thing is that we had a lot of discussion on the precise medications that would be recommended and the group that we put together categorically, again, looking at the -- also the beta recommendations which is national, is that Ketamine is not recommended and instead, we felt it was best to put in the protocol that under medical

control, considerations would be a midazolam was some of the dosing.

Haldol and Diphenhydramine because these are agents that are carried on ambulances. And they are also the drugs that are by and large will take care of a variety of etiologies for these agitated behaviors.

So again, there is a few boxes. We can give you the reference. Maybe Amy can send that around at some point. That would be really helpful, I think. But I would -- I'm going to stop right there and certainly have any of the committee members discuss this any further.

And particularly very indebted Dr. Havens and Dr. Vera Feuer for their very, very great expertise in this area. So I'm turning --

CHAIRMAN COOPER: I'd like to -- pardon me.

MR. VAN DER JAGT: I'm turning it back over to you.

CHAIRMAN COOPER: Thank you.

MR. VAN DER JAGT: Yeah. And one thing, our -- if you bear with me. I'm dealing with an emergency and I have to call a 911 number again.

Okay. So if you can bear with me, and just keep going on with the discussions, that would be wonderful.

CHAIRMAN COOPER: Sure. I'd like to join Dr. van der Jagt in -- in thanking Doctors Vera Feuer and Jennifer Havens for their incredibly important inputs to this -- this project.

I think all of us recognize that that a -- when an agitated child, particularly a young child is not the same as a large teenager anymore in excited delirium for which Ketamine may be an appropriate agent.

Rather, I think the -- the gist of the document is and the process that it builds off the work that's been done by the child psychiatrist is really focused on verbal de-escalation techniques primarily and use drugs really not quite as a last resort, but certainly, after all verbal de-escalation techniques have really been exhausted.

I think it was felt that Ketamine was probably not the appropriate drug for most children that, you know, that midazolam Haldol and Diphenhydramine were much more appropriate drugs. And that -- for that reason, you know, those -- those

drugs were -- were included in our discussion in place of -- in place of Ketamine.

And as Dr. Riley indicated, understanding that verbal de-escalation techniques in kids may be somewhat unfamiliar to many of our prehospital care providers. We felt that providing probably a little bit more guidance than usual in the -- in the protocol would be, you know, would be the -- would be appropriate.

So that's sort of the thrust behind the the direction that have been taken. What -- what our plan would be at this point is to -- prior to our next meeting, is to share a straw man of the proposed modifications to the current protocol with you all, so that we can get your -- your input and hopefully get the -- that -- that revision approved at our -- at our next meeting.

But at this time, I just like to ask anyone involved in the committee, not just the working group that put this together, but anyone on the E.M.S.C. committee to chime in with your thoughts, are we on the right track, do you feel that the comments that Dr. van der Jagt has made and a little more detail than I've made.

Not to mention the general direction and, you know, that I outlined it. Are we on the right track? So please, anyone from the committee that has -- has some thoughts on this, please don't hesitate to speak up.

MR. CONWAY: This is Conway. Just as a point of interest, there will -- there is going to be an upcoming publication. I believe it's going to be in Peds Critical Care Medicine, or it may be in Critical Care Explorations.

But it's going to be a vast exhaustive overview of pediatric sedation, neuromuscular blockade education, basically, an A to Z review of the pharmacology of all of these agents. It was initially going to be unveiled in several weeks in Puerto Rico at our annual meeting, that was canceled yesterday.

So I'm not exactly sure when this will come out in the journals, we were aiming for February or March, but it's got all of the delirium scores for infants, children, so people that are just not comfortable with this topic, it will be an exhaustive encyclopedia of everything you ever wanted to need or know. So I'm just putting that out there as an

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educational tidbit.

CHAIRMAN COOPER: And do you still -- are we a part of the group that put that together?

MR. CONWAY: So I was actually one of the reviewers, the editors, and I'm the chancellor of the college where all the guidelines come out. So I've seen it multiple times, yes.

CHAIRMAN COOPER: Do you think it would be possible to get a -- or get the college to allow us to review a -- a final draft or document even if it has not been published so we can learn from it and not make any mistakes in putting this protocol out?

MR. CONWAY: Probably not, but I will ask. They're pretty --

CHAIRMAN COOPER: Thank you so much.

MR. CONWAY: -- they're very stringent on these guidelines.

CHAIRMAN COOPER: Great. I just -- the reason -- the reason I mentioned this is only because SEMAC will not be meeting again until the fall. And if we miss that opportunity to get this before SEMAC in April and, you know, the chances we'll be able to, you know, get anything done really

before the end of the year are pretty slim.

And at the present time, our only option in this protocol is Ketamine. And as you've heard from our discussions, those do not seem to be the most appropriate drugs for children, basically, young children who are agitated.

MR. CONWAY: Agreed. And I will -- I will make the call and we'll see where we go.

CHAIRMAN COOPER: Thank you very much.

MR. VAN DER JAGT: Can I have a quick question? Go ahead first, go ahead first.

MS. FEUER: No, I was just gonna say maybe we can send, Ed, just some of the suggestion that the sub-committee came up with and to just take a look at them to make sure that they don't look, you know, polar opposite from what you've read in the -- in the review. Because if it doesn't come out before the S.E.C.M. meeting, that's been changed, what, till --

MR. CONWAY: April.

MS. FEUER: -- late April, I think. Yeah. Virtually so. So the timing is it's troublesome.

MR. CONWAY: You know, we -- we put it

in for the journal long in advance. So I think it will probably stay -- it was the February issue, I think they wanted it to come out. But I'll check -- I'll get back to either you Vera or Art.

MR. VAN DER JAGT: And Dr. Conway, just a quick question about that also. So the article you mentioned, really it just sounds like a fairly comprehensive overview. Is it geared primarily to E.D. and inpatient? The reason is because this protocol, of course, is for out of hospital.

MR. CONWAY: Right. So --

MR. VAN DER JAGT: We struggle a little -- we struggled a little bit with that only because also in the beta recommendations, there were multiple drugs. There were all different kinds of etiologies.

You know, and it was fairly complicated, and I'm -- so I'm just wondering the direction of the article you mentioned.

MR. CONWAY: So obviously, it's for critical care, but it's an exhaustive overview for anybody that wants to look up any of the score, anything that's -- that's available. But again, the

focus as you're aware, is for the critical care unit.

But again, we get called to use these drugs all the time in the E.R. To our psych E.D. to help our colleagues over there.

MR. VAN DER JAGT: Sure. Okay. Great. Thank you.

CHAIRMAN COOPER: Let me just say that, you know, we will be happy to get the, you know, the -- you know, the conceptual points out to everyone. You know, a specific protocol that -- can only be distributed, after it's been appropriately vetted by the Department to the committee.

I will follow Amy's and Ryan's guidance on this, but I think that the general concept probably could be shared unless I'm -- unless I'm wrong about that, Amy.

SECRETARY EISENHAUER: I will find out what the process is for sharing proposed protocol. I know the documents that we've been working on has draft and all of that all over it. But I will check on that.

And, if appropriate, we can share the draft. Otherwise, I'm happy to share all of the background documents that have kind of been

accumulated just so that if people are -- are curious, they can read, you know, the beta documents and see all the other work that kind of went into making these suggestions.

MR. CONWAY: And Amy, certainly in the past, we have shared some drafts of things. We were going through the A.L.S. protocols so to get input. And this has been vetted fairly extensively by a sub-committee already, so it just seems like it would be very helpful to see it in paper because, you know, with wordsmithing and trying to be very specific, you know, maybe that would help at least.

SECRETARY EISENHAUER: Of course.

CHAIRMAN COOPER: Any other comments regarding the general thrust of the -- of the -- where we are with the progress and we'll go from any of the committee members.

I'm presuming then we have the committee's, you know, agreement to proceed in the direction that we've outlined. Is there any objection to that? And then, hearing none, that's what we will do.

And we appreciate your -- your input and are particularly appreciative of your bringing

the attention of that document and we look forward to your help in, perhaps, getting it to us earlier that others might be able to see it, if that is possible. Thank you.

Okay. So moving on to the next item of Pediatric Sepsis Initiative and again, van der Jagt, if he will take the lead on this. This, I think, would be a pretty short report because, you know, we're not -- we haven't gone quite as far with the Sepsis initiative as we have with the agitation initiative.

But then, we will fortunately have a report from Division of Quality and Patient Safety within the Department as to where we are with respect to the Pediatric Sepsis Initiative. And make sure our hospitals are participating. Elise, please.

MR. VAN DER JAGT: Yes, and this will be like you said, Dr. Cooper, fairly a short report. We have actually met several times, also a group of people from this -- from our E.M.S.C. advisory committee.

So what we started off by doing is by looking at the 2020 Surviving Sepsis Guidelines, which were just recently came out, and then, to look

and see whether we needed to change anything, particularly in the pre-hospital protocol.

So as we went through that, that went around a few times, some suggestions that we made regarding that. This is back late in the fall. And then as we were working through that we recognized I think that one, the -- one of the issues came up was, well, how many patients does this really going to impact?

You know, how many patients truly have a severe sepsis, septic shock, or now it's called sepsis with organ dysfunction, you know, that this would be relevant for, that was number one. So the information about that was unclear.

And the second thing is, with the advent now of a new approach, which combines a sepsis and M.I.S.C., which you'll hear about in a second in a new data set, which is primarily outcome based. It became, I think, aware -- we were discussing at least that maybe what we should do is to consider what kind of data might be shared with us from that data set.

So that could inform what we might advise with respect to management in the pre-hospital care arena, in E.D. and et cetera, all the areas that

E.M.S.C. is involved.

So that is where we are, what kind of data do we need? How much of a problem is this? And then, that relates then can we develop the energy to putting some change -- mild changes in the current E.M.S. protocols because we know that that process is quite laborious, obviously. But does necess -- we want to make sure it's up to date.

So I think that that sort of summarizes my understanding of this, Dr. Cooper. Certainly anyone else from the Committee can feel free to respond if I've missed or left anything out.

CHAIRMAN COOPER: All I will say, at least, in addition to what you have already outlined is that our focus really remains on the earliest possible recognition of -- of sepsis for our E.M.S. colleagues in the field.

For reasons that should be clear to all of us and the sooner we start treatment, the better the outcome. And that's really been very clear from the data that's been amassed over recent years. Any other comments?

Hearing none, then, we'll move on to a report from the Department. Is our -- is or

colleague from the Division of Quality and Safety with us?

MS. OSINAGA: I'm here, Dr. Cooper.

CHAIRMAN COOPER: Wonderful, Wonderful.

MS. OSINAGA: Hi, everybody.

CHAIRMAN COOPER: There you are. Hi.

MS. OSINAGA: Yes.

CHAIRMAN COOPER: Okay. Good to see you. Thank you for joining us. It's Dr. Osinaga for those of you who do not know Dr. Osinaga, I've met her recently, and you are very, very good to have her and her colleagues from the Division and the Office of Quality and Patient Safety with us today. And I know that they will have even more for us at our next meeting later this year. So please, go ahead, Dr. Osinaga.

MS. OSINAGA: Thank you, Dr. Cooper, and hello, everybody. Dr. Cooper said my name is Alda Osinaga, and I am one of the Medical Directors in the Department.

I specifically work within the Office of Quality Patient Safety. I'm the Director of the Clinical Center and it's within my center that we

have the Sepsis Care Improvement Initiative.

And I understand that -- that we have spoken at this meeting before about this Sepsis Care Improvement Initiative, but I have not been present at those -- those meetings. I've been at O.Q.P.S. for about a year, or actually now it's been more than a year. It's been a year-and-a-half actually. I didn't even realize how time has gone by.

Prior to working in O.Q.P.S., I worked in the Office of Health Insurance Programs and Medicaid Policy, and we did a lot of work concurrently with O.Q.P.S. I worked really closely with Dr. Friedrich and Dr. Alicandro who I imagine are the two who spoke to this committee in the past, and so they are no longer here but I work on the same project that they did.

And so I might be repeating some things that you all know, but since I don't have the background of what you know, I just want to make sure that we're speaking from the same -- from the same baseline so that my updates -- updates make sense.

I don't have any slides to present today and so if anybody has any questions, at any point, just -- just let me know. So we, again --

CHAIRMAN COOPER: Dr. Osinaga?

MS. OSINAGA: Yeah.

CHAIRMAN COOPER: May I interrupt from here for one minute?

MS. OSINAGA: Uh-huh.

CHAIRMAN COOPER: Just for your information, most of what we heard in the past as the committee were reports from Dr. Friedrich and Dr. Alicandro about the sepsis data itself, you know, in fact, Sepsis summaries that we -- the data findings from -- from the project.

And there is another group of which you are familiar with maybe that -- that is an advisory group under your -- your office that has actually had the responsibility of commenting on specific changes or directions that you want the pediatric as a part of this program to take.

Our role has been to be educated by -- by the Department in this area and to offer, you know, a sort of thirty thousand foot view suggestions rather than maybe five or ten thousand foot suggestions to the Department, okay?

MS. OSINAGA: Okay.

CHAIRMAN COOPER: Let's go to our --

what is in our role?

MS. OSINAGA: Okay.

CHAIRMAN COOPER: Thank you.

MS. OSINAGA: Thank you. And so I actually don't have any data to present today. And this is a good -- we'll explain why we don't have data to present today.

So the Sepsis Care Improvement Initiative, the goal is to decrease sepsis mortality rate deaths due to sepsis. And in 2014, regulations were passed that the Department collect data from hospitals about sepsis cases, but not all sepsis cases, about severe sepsis and septic shock.

And we collect those for all -- all patients, for both pediatric patients and for adults. And the hospitals send us this data and so that we can look at mortality, we can look at mortality per hospital, we can publicly report that and then we can give that data -- data back to the hospitals.

And so we've been focused mainly on -- on hospital care and what is going on in the hospital. I know here, we're speaking about beyond hospital in the spectrum. So this is a good place for us to sort of try to think about outside of the

hospital what to do about sepsis.

So we had traditionally been getting the data by having the hospitals go in and look at chart extractions. They would go into patient's charts, look for the -- the data that we were requiring them to send to us and send it back, but we've changed that.

We've changed the data extraction method. We're not asking hospitals anymore to go into charts, we're asking them now to submit things electronically to us. And we're doing this for two reasons.

One, it's not as resource intensive. And I think when COVID came in, we saw that there were, you know, there are just other priorities that the hospital has to do and at times like this, how can we make things that are so -- that aren't so resource intensive.

So electric data extraction can do that for us. And we also think that's the way to standardize things. So everybody identifies sepsis in the same way, everybody identifies diabetes in the same way.

And so we have produced that that's

the sepsis new -- sepsis data dictionary, this is a new way of doing things. And we have just started collecting data for that starting with calendar year 2021.

So we currently do not have data yet for pediatric cases because the hospitals first started with sending us data on adult -- adult cases. So they started doing that over the summer. And the first submission for pediatric cases is going to be due in February, so next month.

And we're asking the hospitals to send us these pediatric cases, starting -- going back to December 2020. So we anticipate that we will have a full calendar year by December 2020 to December 2021.

So we should be getting that data from the hospitals, again, next -- next month. So we have until 2019 sepsis data that was done in the old way, right, the chart extraction way. We did not have hospitals -- the hospitals did not have to send us any data in 2020 because of COVID, we did not require the hospitals to submit data to us.

And then, starting in 2021, we will have data again, same things, severe sepsis and septic shock but collected in a different way. And

so this also brings up what we're -- what we're getting.

So we're getting these sepsis and septic shock cases but also asking for in the pediatric, for any patient who was hospitalized for COVID including M.I.S.C. I think this is what was referred to, right, Dr. Benny (phonetic spelling) had said that we will be getting data on sepsis, M.I.S.C. and COVID patients but not all COVID patients.

COVID patients, pediatric patients who are hospitalized. And really trying to be able to use that data to see the intersection between sepsis and COVID, right.

There are COVID patients who have a sepsis syndrome. So we're trying to be able to characterize, which will -- we're hoping that we'll be able to look at sepsis alone and sepsis with COVID. And so that is a new part of this, that we did not have before.

COVID wasn't here before but this is something that with a new data set that we're hoping to get. And when we're looking at this, data that we're collecting, we collect comorbidities, we collect to see what -- what conditions the child came

with.

We use that to try to see if we could do with risk adjusted mortality rate calculations for pediatrics. We have not done that yet in pediatrics, we do that in adults. And so that's something that we're trying to work out. We're working at that now to try to figure out our modeling. It's another announcement I wanted to make.

So we're looking to see if we can do that. But we look to see, you know, what -- what children are coming with, if they have pre-existing conditions and their septic. We have asked the hospitals to send us data if the -- if the pediatric patient has COVID, M.I.S.C. or flu so they have other diseases along with the sepsis.

We are looking at what treatments they got in the hospital, to see if they had to get dialysis, if they had to get mechanically ventilated, if they needed ECMO, if they got I.V.I.G., and then we're also looking at what we -- how we try to characterize severity.

And the way that we're doing that is collecting vital signs from them and collecting certain blood -- blood tests, and then, also to see

if there is any organ dysfunction.

So that's the data that we're getting and, again, remember, it's it's really just to look at -- it's predominantly to look at mortality. And what we feed back to the hospital is we feedback data to the hospitals, we're trying to make sure that we do this quarterly.

We're creating right now what would be the quarterly report. But for them to be able to get their own rates of hospitalizations, their own rate of mortality, and to be able to compare them to other hospitals that are of the same size or in the same region, and so that they are able to look at their -- look at their cases, look at their outcomes, but also to see how they compare to others.

And we're hoping that data will be useful to them so that they can look at it over a trend. They can see what they are compared to the rest of the State, compared to the rest of the region. And for them to be able to use that to look internally at their processes to see how they might be able to improve mortality.

But again, what I -- again, the focus here has been traditionally looking really at

hospital data, to look at that and then to give back to the hospital about the care delivery in the hospital. But here today, we're talking about care of sepsis patients.

Before -- before the hospital, and I think even after that too, you have to think about the spectrum of care after -- after the hospital stay and I know that one of the things that was raised and asked at the last meeting was whether we could see in our data if a person was brought to the hospital by E.M.S.

And so we did look back to see that. Remember, we're taking everything, trying to abstract electronically. So trying not to go to a chart to see if there is an E.M.S. note or anything.

And when we brought this up to -- to our group of folks that, you know, Dr. Cooper just mentioned, we have an advisory group, but we also have a group that is specifically from a coding perspective and what they can pull from their records.

They said that that information is not something that's readily available at this point. So in their system that they have, which they're able to

electronically extract from, they don't have like an easy flag that says that this person was brought in by E.M.S.

So we don't have a good way of doing that at this point, but maybe we can figure out something in the future. But it definitely sounds like the hospitals would have to make modifications to their systems to be able to collect that data in a way that is easily extractable. That doesn't require going into -- into the -- into the medical record.

So just -- just so, again, where we're at with this is we have a new way of collecting data. It's electronic extraction. We have not received any data yet from pediatric cases, but we should be getting in February.

The data is both on severe sepsis and septic shock, but also COVID and M.I.S.C. And again, the outcomes are for mortality, we're going to see if we can collect and start making a risk adjusted mortality model for pediatric patients. So let me stop there and see if anybody has any questions.

MR. VAN DER JAGT: Dr. Osinaga, this is Dr. van der Jagt --

CHAIRMAN COOPER: I'm sure we'll have

questions to follow, thank you. Elise, please go ahead.

MR. VAN DER JAGT: Yeah. Just this -- this last point, I think is a really important one. I know we've talked a little bit about this in our other -- other discussions.

The issue of E.M.S. and hospital data, which now includes E.D. data. I just would like to at least go on the record saying, I think that that is a very important piece of information because we are trying to catch kids with septic shock, you know, organ dysfunction with sepsis as early as possible and the frontline person is really often the E.M.S. provider.

So as we look at things like, you know, changing protocols, looking at training, of education about this, trying to do the very best we can, as soon as we -- as that's recognized, there needs to be a linkage between those two outpatient, I mean, E.M.S. data sets and the hospital dataset.

It's very reminiscent of about fifteen, twenty years ago, when we were looking at just hospital sets, and we did not have a linkage to emergency room datasets. And then there was a whole

data linkage that was developed, even in our own region in Upstate New York, we developed a probabilistic linkage kind of data to try to figure out how we would do this.

Well, that's resolved now because E.D. and hospital now are together, but I would like to us, to like your particular group -- to really consider this very seriously. Whether that linkage can be established, even if it is just started out as a pilot.

I just think, I cannot under -- overemphasize the importance that I think this is for the patients that we're dealing with pediatrics.

MS. OSINAGA: Now, that the electronic -- almost all pre-hospital care reports are now electronically collected data wise, and one of the fields in that data collection is hospital transported to.

So maybe there is some way to use that linkage going from the E.M.S. data to the hospital data and then linking up the patients that way.

So I don't know -- I don't know how they enter -- how the different databases react with each other yet, but certainly, I think that might be

something to consider.

And this is all that Chairman -- we have -- we have a field that allows us to know if a person was transferred from hospital to hospital, if they came from a nursing home, if they came from a home but so -- but in that not the details of if they were brought from the home by, right, by E.M.S.

And so that is something that we don't have and, you know, I don't -- I don't know all the nuances between every -- the hospital systems and the different -- the different ways but you're right.

The only way we're going to know about this is, right, just to explore this a little more, just to understand where -- where that data lies in the -- in the hospital. And other than like the E -- if they're separate, and if they ever get -- if they ever get combined.

But -- but what -- the feedback we heard was that it just isn't something that they have readily available at this moment. And you're right, having this is not just for sepsis, right, that -- that piece of information is not just useful for sepsis, right? It's useful for so many other things if we can have that, that link.

MR. VAN DER JAGT: But I do think that, Dr. Osinaga, that you are in a wonderful position to advocate for that for both adult and pediatric patients that this happens because those linkages are important.

And I think in speaking for the E.M.S. system, I really feel that it would recognize that the E.M.S. system is a critical part of the health care spectrum of giving care to pediatric and adult patients who are undergoing emergency situations and emergency illnesses and injury.

So maybe this could be a vehicle for saying this needs to be done, whether it's going from the P.C.R. or the pre-hospital care record, which Sharon mentioned, to the hospital or vice versa but that linkage really does need to occur.

And we are in a wonderful position in New York State having developed that sepsis thing, the whole sepsis database is required. We are in a great position, I think in the country to really make that happen and using that as a prototype.

MS. OSINAGA: And I guess --.

CHAIRMAN COOPER: Any other comments or question for Dr. Osinaga? Okay. Alda, do you

want to respond?

MS. OSINAGA: I actually have a question for the group, Dr. Cooper. I'm thinking about other than having that link, right, that data link of knowing which cases, because the overall goal with, I think of having -- be able to know that someone was brought in by E.M.S. would be to see what the outcomes were if someone was brought in by E.M.S. versus someone who wasn't and then also if there were any differences in between that.

So that would be your overall outcome there. But just what I wanted to hear from the group, if there any other data -- data that would be -- that would be useful to think about -- when we think about sepsis, again, what we're gathering is really our look is to look at outcomes and to look at mortality.

We've been talking also about readmissions and thinking about whether we can start looking at readmission. So people who are discharged and then readmitted and why they might be readmitted and when they were and then their outcomes there.

So that's something that we haven't looked at, but we're also thinking about that as

another outcome. I'm not sure if there is any other data points that this group feels would be important for your work to think about when you're looking at sepsis.

Again, we're getting data at this point directly from -- from hospital, so the hospital stay but -- but we can think about broader than that too. But I'm just wondering if there was any feedback from the group here?

MR. VAN DER JAGT: Dr. Osinanga, I know I'm talking an awful lot here, but one of the thoughts I would have is that, you know, there are outcomes, then there are also interim outcomes.

So that I think how a patient presents to the E.D., in what condition is probably an important consideration. You know, the patient let's say, for example, worst case scenario is the patient comes in floridly hypotensive and febrile, you know, that's a very different situation, than a patient who comes in with a little bit of fever and has an elevated white count, and it's sort of a little bit borderline, and they get one fluid bolus, and they're fine.

You know, so I think that, that

becomes important in that if you have patients who have presented, who present with their findings as being in a very tenuous situation, that would then reflect on the, potentially, the outcome of E.M.S. management on -- on the outside, because they maybe would have been able to to make that patient improved by the time they got to the E.D.

MR. CONWAY: I might just comment on -- Elise, on this. By no means all, but I would say the great majority of children who are transported from the field to the Emergency Department and has the benefit of paramedic transport will receive actually probably less fluid.

Actually, you know, would necessarily think appropriate for first line, there is an E.E.D. It's pretty good data from the pre-hospital environment that in a relatively short distance, limited duration, urban transports, and the amount of fluid that kids get when being transported by -- by paramedics have been, you know, maybe an average of as little as five milliliters per kilogram, in terms of a bolus.

And of course, if you're talking about a longer distance transport, I'm excluding for the

moment, you know, the -- in the hospital transport teams, as that they have -- that is a very different animal.

But I mentioned this only because as we all know, you know, the data that was forthcoming from the Department, you know, under Dr. Friedrich and his colleagues earlier in this program really focused on the fact that, you know, that fluids were, you know, were the -- probably the one change that in addition, antibiotics, of course, but the one thing that really did improve the situation and the more fluid they got, the better they get, and I'm sure you're familiar with the saying.

And an early administration of antibiotics are of course key, but that's not something that pre-hospital providers are generally in a position to administer. So you know, on what are your ideas on how we can potentially, you know, deal with those two issues, you know, the antibiotic issue and the fluid administration issue, given that I can't imagine a situation whereby they would be given by anyone other than a paramedic under our current system.

MS. OSINAGA: And -- and Dr. Cooper,

in this iteration of the data dictionary, in the past, when we did data abstraction, fluids were a data element that was collected. But in this new data dictionary fluids are not collected.

One, because in the past analysis, the Department was also calculating process measures. And so they needed that information and now the Department has just going -- moving toward outcome measures, at least from the Department side to -- to analyze and to collect.

But also, just with the data abstraction to figure out when the timing of the bolus -- like the fluid was and to understand how much fluid was given when was something that was not easily extractable to understand that from the -- from the E.M.R., to understand how much came out at what point and at what time.

Often orders went in after they were -- they were administered. And so the timing was just harder to get from this -- from the way that we're getting the data now.

But still, always, the data dictionary is not set in stone. So it does get -- it does get looked at, it does get modified. We can always -- we

can always change, make -- but right now, in the data collection that we're getting, we don't have anything on fluids.

We have -- we do have an -- vasopressor -- a pressor administration, so we could see if someone did get some vasopressors, but not necessarily. And that's looking at more of a severity, but not necessarily looking at fluid.

MR. VAN DER JAGT: Dr. Osinaga, I totally agree with you. And I think looking at process measures go into outcome measures is by far the best way to go. I really do agree completely with that. But my point was only in that the condition of the patient on arrival in the E.D. is an outcome of sorts, of what happened prior to the E.D., and there is how do we capture that.

And it would actually be most important for patients who are extremely ill with septic shock kind of thing, rather than just a patient who has a little bit of sepsis, you know, so I don't know how that could be captured.

And maybe some thought might be given to that because it is a hospital data, of course, and so it would not be the management in the hospital, it

would be really related to the very condition of the patient at the time of arrival.

MS. OSINAGA: And right now what we have our vital signs. So blood pressure, heart rate, respiratory rate, and we have a few blood tests. So we have white blood count, blood cell count, lactate, Cohex (phonetic spelling), and I think that's -- and creatinine. I think creatinine.

And we have those on arrival and then asking for two more after that so we could see if there was a trend where they were normal on arrival and then got worse, if they were abnormal on arrival then got better, if they were abnormal, just we -- we're trying to figure out if we could do it that way.

We need to figure out the picture -- pictures at this point, it's a vital signs and some blood tests. And we're hoping that that will with some time. So like I said, at some beginning, three after and also max, unless it's something that we were looking for a minimum.

MR. VAN DER JAGT: This goes back to the question of what kind of data might the E.M.S.C. Advisory Committee find useful from the larger data

set.

And so, for example, let's say you would take a hypotensive patients. How many hypotensive patients are we talking about in New York State, you know, that come in who already have a diagnosis of septic shock that is based on hospital data coding.

How many of those came in hypotensive. If we find out that it's one patient out of the entire State, we're not going to devote much energy to it but if there are a number of patients, and then, you put that together with outcomes --

MS. OSINAGA: Yes.

MR. VAN DER JAGT: -- that are death, then I think that's the kind of data that might be useful for us to look at. And this has been particularly important because we just discussed the fact that many of the ambulance agencies, only I think about twenty percent of them have blood pressure cuffs for pediatrics.

You know, so I think that those are the kinds of ways that we might be able to use some of that data, even if it's hospital data.

MS. OSINAGA: Very good feedback.

Thank you. Yeah, yeah.

MR. CONWAY: And still with that I would -- if not identified, you know, differences in outcome, right, between various patient groups. The next question is, of course, why, and -- and without at least some very basic process measures that -- that's pretty difficult to get at.

And since the goal of this whole project is impact to decrease mortality from sepsis, you know, I would respectfully submit that that's something that even though we have not -- we recognized that there are tremendous difficulties in trying to collect that kind of information.

You know, I think over time, you know, we probably need to learn how to do that a little bit better than we have in the past. That's just one person's comment. I understand and, of course, we need outcome based measures with that.

MS. OSINAGA: Appreciate that.

CHAIRMAN COOPER: Any other comments from anyone?

MR. CONWAY: Yes.

MS. FEUER: Yes, it's Pamela Feuer. Thank you for that overview, again, you know, on some

of the calls. So I knew that we were going away from the process data, but do you know and in light of this committee and pre-hospital care whether things like not just vital signs, but access are collected.

For example, if someone was, you know, coming in by EMS, and when they had an I.V. or an I.O. because, you know, without that it precludes us from giving, you know, having appropriate fluid. So maybe there's resources or -- or education, you know, things that can go into that kind of stuff. So is that being collected?

MS. OSINAGA: You know, we don't have a variable -- we don't have a variable for that. But you -- but there are possibilities to do that. So we'll take that back. I'll take that back.

What I mean, possibilities to do that, right, there is codes for that. That's maybe something that we can look at. Yeah. Okay.

MS. FEUER: Thank you.

MS. OSINAGA: Thank you.

CHAIRMAN COOPER: Any other comments or questions for Dr. Osinaga? Hearing none, I really appreciate your time, Doc, and being with us today here and then I hope that’s said and we look forward

to hearing from you a little bit later this year.

I know that you're in the process of getting the most recent, you know, pediatric data set at the -- at present time. And hopefully, by the time of our next meeting you will have, you know, some data to present and let us know where we are with respect to the -- the, you know, the aspects of a statewide data project, and if we're making any progress.

I sure hope we are and I know you've said so, so.

MS. OSINAGA: Yes, yes, thank you. It's really nice to be able to speak to all of you. Thank you.

CHAIRMAN COOPER: Okay. And we look forward to seeing you next time. Thanks so much. Okay. All right. Okay. That concludes our old business wrap up.

Now, it's time for us to move on to new business. And Alda, you're welcome to stay if you wish, of course. And I think the first item on the agenda is the COVID vaccine and our views as to whether this potentially might be extended to children younger than five. And --

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SECRETARY EISENHAUER: Dr. Cooper?

CHAIRMAN COOPER: Yes.

SECRETARY EISENHAUER: We have a question in the chat related to this topic. So when you're ready for questions, please let me know.

CHAIRMAN COOPER: Sure. Yeah. No, I saw that. And I wondered that if that question is with regard to a mandate for vaccination, and how does one reconcile support of such a mandate given the reports of patient and parental autonomy.

This is a pretty tough question, but for all of us to focus on and if you recall at the last -- at one of our recent meetings, I think it was our last meeting, we did choose to write a letter to the commissioner strongly recommending vaccination for pre-hospital providers, since at the time, we recognize that unvaccinated children represented a potentially huge group of patients at risk, not only for illness, but also transmission of the illness to others around them, particularly their parents and families.

And indeed -- and especially, I would say, if their illnesses were -- were subclinical and they were asymptomatic. So we all know that since we

discussed this in any great detail, the C.D.C. has recommended that vaccination be available for kids up to age five. Previously, it was only available to age twelve and now it’s down to age five.

So we’ll look for discussion on this so we're open to discussion on this issue, how do people feel about -- about a recommendation to the Department with -- regarding vaccination of -- of young children.

I will note, of course, the Commissioner does have a strong background in public health and infectious diseases, so it might be an opportunity for us to, you know, get the ear of the Commissioner on this issue.

MR. VAN DER JAGT: Dr. Cooper?

CHAIRMAN COOPER: Any comments from anyone? Yes, go ahead.

MR. VAN DER JAGT: Yes, I believe we did discuss this last time. And I think the letter that we wrote, I believe was just as you indicated it, but maybe it wasn’t clear to me how it was said, that we specifically did not support the mandate, we supported the vaccine that it should be given to all, you know, kids down to age five as I remember, at

least.

It was not -- because we did talk about this issue of mandate versus no mandate, I think.

CHAIRMAN COOPER: I think our letter was actually focused on -- on E.M.S. personnel, and it wasn't focused exclusively on the kids, and that is the issue before us now.

MR. VAN DER JAGT: Okay. Maybe I misremembered.

CHAIRMAN COOPER: I mean, honestly, to me, since I don't hear anyone else speaking, this -- this is a relatively easy thing for us to do, and the Centers for Disease Control and Prevention, you know, and, of course, the F.D.A. have -- have both recommended this and approved of the vaccine for use in kids down to five.

You know, I think, you know, there is no reason that we could not as a committee have a strong recommendation to the Commissioner that we believe that that, you know, the Department should, you know, really engage in a full-court press to try to get as many kids vaccinated as possible.

You know, understanding that the issue

of, you know, just the issue and parental autonomy means that, you know, it was a -- it's is an important one. You know, at the same time, you know, prevention of illness among the population at large is no less important.

Not to mention that the rights of an individual. So how do people feel about that? I mean, are we in a position that we might want to make a strong recommendation regarding or any recommendation regarding vaccination or should we leave it just as an option as, you know, the C.D.C. has indicated? Anybody?

MR. CONWAY: I think as pediatricians and sitting on this committee, we owe it to our patients to speak out strongly as strong advocates for this -- for immunization as the data comes out. I mean, we can follow the A.A.P.'s guidelines for specific.

I mean, you got seventy thousand board certified people supporting the organization and they have a very strong, as we all know, political arm in Washington. And I think it would do our patients well to follow suit and support it the strongest that we can.

CHAIRMAN COOPER: Thank you. Others?

MR. VAN DER JAGT: I just put a comment in the chat box. I strongly support the vaccine. I do not support the mandate.

CHAIRMAN COOPER: That's essentially the same position that we took last time. It was a strong recommendation rather than a mandate.

MR. VAN DER JAGT: That's correct. I do think --

CHAIRMAN COOPER: Is there other --

MR. VAN DER JAGT: -- I do think that -- I do think that by however, if we say nothing, that's that speaks itself. That's also a decision. And I don't think we should go that route. I think we should definitely strongly support the vaccination piece of it. Because that's the --

(The meeting resumed)

MR. VAN DER JAGT: You know, I mean personally I feel the mandate is not the one the way to go, but I do want to make sure that E.M.S.C. Advisory Committee is on record on saying we absolutely strongly support the vaccination of -- of children with this vaccine.

MR. CONWAY: Yeah, I agree we can't be

silent about this.

CHAIRMAN COOPER: Go ahead, I'm sorry.

MR. CONWAY: I -- I -- we can't be silent on this. We need to be heard. And I would -- although I might agree personally with the mandate, I also would keep us apolitical, let's stay out of political arguing and let's just put forward the science let’s what's do -- what's -- yeah, let's do what's best for kids.

I mean, we -- we have a big issue here with adult caretakers in the City Hospital System not getting the booster shot. And my concern is, since the Omni hasn't been as overwhelming, people aren't as sick with the feeling starting to develop that, hey, this wasn't so bad. I got it. I probably don't need a booster.

So I'm -- I'm very concerned about that as well. And -- and again, I think we need to stand behind the kids and the best science that we have. And I would follow the A.A.P.s recommendations.

CHAIRMAN COOPER: Okay. Can I take that as motion from you?

MR. CONWAY: Yeah, my motion would be

that the group put forth that we strongly endorse and support vaccinations for all age groups of which there is supporting data following A.A.P. supporting guidelines.

CHAIRMAN COOPER: Is there a second to that motion?

MS. CHIMUENTO: I clarify before we -- we get there so is that all vaccinations Dr. Conway or is that the COVID-19 vaccination?

MR. CONWAY: Let's go with the -- let's -- well, let's go with -- let's stay with the COVID, let's keep it focused.

MS. CHIMUENTO: Okay.

CHAIRMAN COOPER: Is there a second to that motion?

MS. CHIMUENTO: I'll second it, is Dr. Chimuento.

CHAIRMAN COOPER: Very well, Dr. Fuer.

MS. CHIMUENTO: Sharon -- Sharon Chimuento.

CHAIRMAN COOPER: Sharon -- Sharon, thank you Sharon. Discussion. Hearing none, all in favor please signify by saying aye.

MS. CHIMUENTO : Aye.

MR. CONWAY: Aye.

MS. FEUER: Aye.

CHAIRMAN COOPER: Oppose, abstentions? Hearing none, that motion carries without dissent. A letter will be prepared to that effect. Thank you. Amy, please refresh my memory the next item on the agenda is what?

SECRETARY EISENHAUER: It is discussion of New York State staffing shortages --

CHAIRMAN COOPER: Right, right.

SECRETARY EISENHAUER: -- with regard to patients.

CHAIRMAN COOPER: Yes. I think all of us are painfully aware of the fact that as many as fifteen percent of our staff are -- you know, have been intermittently out with -- with -- with COVID, particularly given the enhanced transmissibility of the -- of the recent -- recently identified Omicron variant.

We're also aware that there are a lot of variants that have -- that -- that -- that are emerging ones from Cameroon, France and one from Cyprus. And the -- the early data is not yet available to tell us, you know how -- you know,

pathogenetic and virulent each of these new variants may be.

So let us all hope, pray that they turn out to be less pathogenetic and less virulent than -- than the variants that are currently circulating among us, chiefly Delta, and Omicron. But that has led to severe staffing shortages, you know, throughout the State.

It hits pediatric units as much as it hits adult units. I think adult units more severely at least with our experience in New York City if that is any indication. Is there anything that we -- we -- our Committee can say or do that could, you know, help enhance the -- the -- our ability to surge to meet demand -- sorry, Director Greenberg did earlier referred to the issue of load balancing among various facilities.

I know that, you know, the Health and Hospitals Corporation in New York City, you know, has -- has done a much better job with load balancing this time around than it did previously. I don't know about situations elsewhere in the State, however. Elise, Pamela, do you have any thoughts in that regard?

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MS. FUER: Sorry, I was just on another call. Could you repeat the question briefly?

CHAIRMAN COOPER: The question is basically, is there anything that our Committee can do to assist our pediatric colleagues elsewhere in the State. And where staffing shortages that -- that they may be experiencing due to the, you know, the enhanced pathogenicity of the Omicron variant? Sorry -- yeah, that's right the pathogenicity , that's right.

MS. FEVER: I mean, one thing -- and I think many of us are and in certainly the intense groups and staff resources for practitioners who may not see as many patients or didn't see as many patients to start with -- with, you know, protocols or -- or recommendations for treatment, you know, in some of the outside places.

But as far as providing actual staffing, I don't think so, we're all struggling even the non H.H. hospitals are struggling with both physician, and nursing, and respiratory therapy resources.

CHAIRMAN COOPER: I know we're all struggling, yeah exactly, I mean, I don't know that

it would be terribly helpful to try to set something up, you know, particularly since we all expect the, you know, the -- you know, the Omicron has peaked shortly over the next, you know, few weeks, at least according to the information that we're all receiving.

I don't know if there's any -- there would be any value in our trying to, you know, as a Committee address the staff shortages in some way. Any thoughts? I see Pamela's raising her eyebrows and saying maybe not.

MS. FUER: I don't have any solutions, but I do want to mention that E.M.S. is also being similarly affected because not only E.M.S. providers out with COVID or exposure to COVID, but we also have many of our E.M.S. providers who are now working part-time jobs helping in the emergency departments.

And then on top of that, we have prolonged delays at the hospitals so the -- the crews can't get back into service. So -- so the complications are not just the hospital level, but out in the -- out in the field as well. And again, no solutions right that I can think of.

CHAIRMAN COOPER: Okay. I don't know

that -- I don't know that there's a lot this Committee can do at this particular point. Again, particularly since, you know, we expect the Omicron peak to subside over the next few weeks and we have no idea what's going to happen with these new variants that have been identified in Cameroon, France, and Cypress.

Let's just pray that -- that they prove to be something manageable, okay. Okay. So since we have no solutions only hopes and prayers as to the rest of the world, I think we need to move on to our next item of new business which is base discussion of inner facility transports.

And Amy, can you refresh our -- our minds as to the -- the genesis of this particular agenda item?

SECRETARY EISENHAUER: Sure, so this is related to pediatric patients that are being transported from maybe a local area hospital, but they need -- maybe there's no pediatric department or maybe they were brought there as a critical patient as, you know, critical access.

And now they need to be transferred to a larger facility for whatever further care they

might need, and the related transportation to get there. So obviously, at that point, probably an ambulance would be involved and what would be appropriate.

And obviously, we have members from all over the state and from different arenas in the healthcare system, and maybe what experience they've been having seeing patients after them being transferred.

CHAIRMAN COOPER: Any thoughts, colleagues? I'd be particularly interested in thoughts from areas outside of the Downstate area where transport times tend to be longer and, you know, and inner facility transport capabilities are potentially more limited.

MR. VAN DER JAGT: You know, I think one of the things is that -- this is Dr. van der Jagt. One of the things that we probably don't have as good of a handle on is how many transfers actually occur between -- let's say, facilities that are from B.L.S. versus A.L.S. versus specialty transfers, ... transfers.

I know that our emergency department often gets calls and they just get transported by

A.L.S. or B.L.S. sometimes depends on where they're coming from and what the situation is. But I'm wondering if that data is available, and whether that would be any -- of any help.

CHAIRMAN COOPER: It would certainly be a reasonable starting point. Amy, do you think that it would be possible to get at least a, you know, a -- a first look at this data for our next meeting?

SECRETARY EISENHAUER: Potentially for the next meeting, yes. Our -- we have stolen Jacob, from doing data informatics work and many, many things in the office for today to help me because Peter is deployed with the National, I got back last night.

And Alex is pulling data for -- for the Nash and all of those units. So right now, the data informatics team is a little crazy, but I'm sure by April, we could get Peter to find some information. If you would let me know what you're interested in specifically, so we can pull the most accurate data for you that will be exceedingly helpful.

CHAIRMAN COOPER: I think we probably

need to convey that, you know, a conference call amongst folks interested in -- to this data perhaps to - to discuss what data might be the most useful, I certainly think the data that has been suggested is a reasonable starting point. And that I think we probably need a, you know, more in-depth discussion than we really have time for in this particular meeting.

Does anybody have any additional thoughts at this point?

MS. CHIUMENTO: Would it be possible Amy to send us a list of the data points that are now being collected on P.C.R.'s?

SECRETARY EISENHAUER: There are many, many, many, many data points. I can -- I can send you the NEMSIS documentation for you to review, but it is not in English in any way, shape, or form.

CHAIRMAN COOPER: It is not what, Amy?

SECRETARY EISENHAUER: It's not in English, it's in data-ese, so --

CHAIRMAN COOPER: I see.

SECRETARY EISENHAUER: -- made up word. But yeah, so -- so to look at it, it's not like name, address, birthday, you know, phone number,

like age of patients, right? It's not written out like that. It's written out kind of more like a computer algorithm. So again, I'm happy to share it.

You can review it if you happen to be a data aficionado, but I don't know that it's going to be very clear about what it's looking for or not or any of that.

MR. BERRY: This is Bruce Berry. Just wondering if -- I mean, if we're looking at data, maybe you just started something as simple as, you know, pediatric patients within our facility transports across the state broken down by region. And maybe, you know, especially centers outside, you know, Albany Med, or, you know, so on and so forth.

I know, in our region, most of our pediatric patients go to U.V.M. in Burlington, so, you know, maybe an origination or destination location that includes those areas and just start there with the number that we're talking about overall.

MS. CHIUMENTO: Okay.

MR. VAN DER JAGT: I think also, Amy, if I'm not mistaken, obviously, I see in the records when I look at patients who've been transferred from

another institution to the P.C.R., it looks like it contains both the starting point which is a hospital as a facility, and the ending point.

So you want to get -- those are the ones that facility to facility transports, those are the patients, it seems like that isn't a P.C.R. and to do that in counties. And that would give us also an assessment of whether or not, you know, a smaller hospital transports to a larger community hospital, let's say not to a medical center.

Because that -- you know, that translates into the -- and what happens to those kids, you know, is that the right transfer, is it not, that kind of thing. And that would be a starting point facility, like where I said facility to facility. And I'm quite sure that those are in the P.C.R's because they have to have a starting point and an ending point.

SECRETARY EISENHAUER: Okay. Is -- who would like to be involved in this discussion, or think about it and email me in the next day or so?

CHAIRMAN COOPER: Any other comments? Okay. Well, then I think we are now on to updates from our sister committee within the division or --

or the bureaus -- bureau of ... medical services ... and others within the department, which we collaborate. Amy would you be kind enough to ask our colleagues in order to give their brief reports?

SECRETARY EISENHAUER: Sure. So first is injury prevention, and that's Amy Jagareski.

MS. JAGARESKI: Hi, everyone. This is Amy Jagareski. As Amy Eisenhauer mentioned, I work in the Department of Health in the Bureau of Occupational Health and Injury Prevention. So we have just a couple updates specific to child passenger safety activities that we're working on currently.

The first is that we're supporting a child passenger safety for school bus training, which is from the National Highway and Traffic Safety Committee. This is going to be happening on February 23rd, and this is going to be a pre-offering part of the New York Association for People Transportation Conference, which is happening in Albany.

We're currently also waiting on executive deputy clearance for the script for a child passenger safety roll call video. And this video module will be covering Vehicle and Traffic Safety

Laws surrounding child passenger safety and it's meant for law enforcement as a training to help them understand and better interact with caregivers during traffic stops.

So as I mentioned the script is in the clearance process, but we're hoping to get that produced in spring. And then, the last update I have is that we're currently evaluating our child passenger safety publications, which are available and free on our website, and these are printed materials.

So we're going through and evaluating what needs to be ordered for this upcoming year. And any evaluation that needs to be done as far as translation services, and that's all I got.

CHAIRMAN COOPER: Thank you so much. When is the next meeting with the injury implementation group?

MS. JAGARESKI: So the Injury Community Implementation Group, the next meeting isn't scheduled yet. We're actually in the process of hiring a core State and Injury Prevention Program Coordinator. And so we just finished interviews with them and I just called references this past week or

two.

So we're hoping to hire someone within the next week and then their first assignment will be starting the organization of that, so hopefully February, if not March.

CHAIRMAN COOPER: Okay. Thank you. Amy, next -- our next -- any questions for Ms. Jagareski? All right. Hearing none and the next -- next group?

MS. EISENHAUER: The next group is Family Health and that is with Dr. Christopher Kus.

CHAIRMAN COOPER: Is he with us today?

SECRETARY EISENHAUER: I'll check.

CHAIRMAN COOPER: You said Chris Kus, right?

SECRETARY EISENHAUER: Yes, we're checking.

CHAIRMAN COOPER: Yeah, I don't see him on the Webinar.

SECRETARY EISENHAUER: Right. Yes, we confirm, he is not here. So we will move on to Health Emergency Preparedness, the Central Office with Kate Butler as a party. I know that she has some obligations with the E.O.C. so she may also not

be here.

CHAIRMAN COOPER: Okay.

SECRETARY EISENHAUER: How about Drew Fried from the Long Island region, same office. I don't see him either. He was here earlier. He may have had to jump off. I know that a lot of us are pulling double duty and --

CHAIRMAN COOPER: Yeah.

SECRETARY EISENHAUER: -- working in different centers. Mark Philippy did call me earlier this morning. He has a -- a personal matter out of State. And he asked if maybe you, Dr. Cooper would kind of give an update on the SEMAC and SEMSCO generally going over what we discussed.

And he did mention the Pandemic Triage Protocol that we had kind of discussed.

CHAIRMAN COOPER: Yes, thank you.

SECRETARY EISENHAUER: I can share what documents they had.

CHAIRMAN COOPER: Yeah, that would be great. I would have to say that the major item on the -- the SEMAC, the Medical Standards Committee and SEMAC agenda and the one that consumed by far the most time at the most -- at our most recent meeting,

which was just last week one week ago today was the Pandemic Triage Protocol.

As you recall, this Pandemic Triage Protocol was put into place about two years ago, almost two years ago at the beginning of the COVID pandemic. It was pretty controversial at the time, but as time went by and as, you know, our experience with SARS COVID-2 increased, and treatments improved, and so on and so forth.

You know, the -- the need for Pandemic Triage Protocol seems somewhat, you know, less urgent than it had in the past. However, because of the increase in -- in, you know, the number of hospitalizations of late with the Omicron variants, the department ask SEMAC to take another look at this -- at this protocol.

A lot of discussion went back and forth on this protocol. And we were at one point trying to at the Medical Standards meeting to develop a pediatric version of this protocol. In the -- in the end, however, the group decided and SEMAC ultimately supported the original protocol that is to be activated by regions or by region on a -- on a -- a bi-weekly basis.

In other words -- in other words, if a REMAC recognizes these, you know, the need for implementation of the Pandemic Triage Protocol in that region. And we -- we do so and the protocol is in place or -- or implemented for a period of two weeks, at which point it has to be reconsidered and to see if it's still applicable.

So if we can, Amy just run through the steps of the protocol and as you can see, it begins with all patients must be screened for symptoms. But before that actually happens, the -- the provider who is caring for that patient are expected to don appropriate P.P.E. before initiating close contact with the patient.

And of course social distancing is -- you know, is encouraged. And then the next question is, does the patient have any signs or symptoms of influenza or an influenza-like illness, which of course, could be any of the COVID -- were caused by any of the COVID variants.

So if the patient has a temperature of greater than a hundred point four Fahrenheit or a subjected fever, if the thermometer isn't available or any of the symptoms you see listed, such as upper

respiratory congestion shortness of breath, a gastrointestinal distress, sneezing, coughing, headache-like fatigue, okay, then one moves on to a patient assessment.

If the answer is no, patients are treated according to standard, basic and advanced E.M.S. treatment protocols. So if one doesn't have one of those symptoms, and then moves on to patient assessment, okay. If the -- if the patient is over sixty-five years of age has respirations greater than twenty-two, oxygen saturation less than ninety-five percent, heart rate more than a hundred and ten, systolic blood pressure is less than a hundred ...

If the question -- if -- if any of the answer to that question is yes, if you could scroll up just a bit, Amy continue treatment protocol and transports patient in accordance with, you know, the E.M.S. policy. It's also noted to contact medical control with really difficult or unusual situations.

Now, if you go back just a smidge, Amy, you'll see that E.M.S. is looking at patient assessment although it's not as good perhaps as you would need. A patient under fifteen years of age, pediatric vital signs are supposed to be substituted

for the vital signs you see listed in that box, okay.

Which I think some of some of us found too cumbersome because it implies the need to look elsewhere for the vital sign but you are presuming pediatric vital signs are, you know, are -- are not abnormal, okay. Then one should obtain a relevant medical history, you can see that the medical history here with the exception of immunocompromised is more adult oriented.

And then, you know, in the box below that if the patient has secondary underlying medical conditions other than -- or in relation to ... And again, the congestive heart failure, at-risk population. So all of these assume the question is if the patient has any of these or they're presumed to be risk factors, okay.

As well as if there is something, you know, a potentially higher risk medical history including underlying medical conditions, you know, if consultation with medical control is deemed necessary. It is carried out and on transport in accordance with the current, you know, E.M.S. policy. Now scroll down, Amy to the last section again of the document if you will, okay.

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So the concept here is that a patient who meet high risk criteria, but are not sick, okay, or sufficiently sick to be transported, okay. That these are patients that may meet non-transport or treat-in-place criteria. And if that is the case the -- the provider is obligated to provide the patient with the COVID-19 hotline number for the department and a patient information packet.

But if a patient does insist on transport, medical control is to be contacted for regional guidance. So this protocol is, as you can see, very much adult oriented. And a specific request was made by SEMAC for us to look at this protocol and determine how it could be modified, you know, to be more pediatric specific.

And so in the interest of time, you know, and because this is everyone's -- so most everyone on this committee, this is your first look at this triage protocol. I think again, it would be worthwhile, Amy if we put together a conference call of individuals involved in -- or interested in the pre-hospital pandemic triage issue, and came up with potential modifications to this -- this document that could be printed out at our next meeting and shared

with SEMAC prior to their next meeting in April.

So I'm going to ask anyone who has an interest in this to please contact Amy and suggest any change with respect to the benefits in the transport group. I know it seems like we're forming a lot of little groups here. But you know, all in all, all the good work is, you know, for any organization that's done in Committee, and I think that that will be the same here.

For those who are interested in pandemic triage I think should please let Amy know and we'll get together a conference call in the next couple of weeks to look at this -- at this document. Any preliminary thoughts at the moment?

MR. HEXEL: Dr. Cooper, Doug Hexel here, can you hear me?

CHAIRMAN COOPER: I'm sorry, who's speaking?

MR. HEXEL: Doug Hexel.

CHAIRMAN COOPER: Hi, Doug.

MR. HEXEL: Hi. I -- I want to speak to this a little bit, not -- not specific to the topic of -- of pediatrics. I work in a very high volume agency, we -- we transport close to fifteen

thousand patients a year. We actually used this less than fifty times.

The -- the way that it's written is such that -- that probably, I mean, I can't actually, I was trying to put together the data, you know, looking at our pre-hospital care records, but like ninety percent of the patients we see do not fit the criteria for non-transport, whether, you know, they have a -- a history of hypertension, that -- that's, you know, now criteria that they -- the have to be transported.

On top of that the -- the packet that we -- that we give them from Department of Health, we flip it over on to the back it says, if you have any of these symptoms, call back again and you will be transported to the hospital and of those people that we did not transport, a huge number of them ended up calling back within an hour or two, or, you know, sometimes four or five hours to be transported.

So you know, it -- it was a -- a great idea and -- and did attempts to use it when -- when the, you know, volume was extremely high. But it really -- it was not as effective I think as -- as the hope was.

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CHAIRMAN COOPER: Good information. Any other comments? I think this is a really important opportunity for us to consider this -- this issue, you know, the -- it is likely that at some point that apparently with respect to COVID-19 ... the distribution of the ... children, you know, yet severely affected.

It is that -- it is likely that at some point in the future there will be, you know, some ... So I think this is a really important exercise for us to go through. And, you know, I think that a robust discussion about how this protocol should be modified or a potential, you know, ... you know, should be developed ... a pretty serious concern.

And something of issue you know with -- without any ... and SEMAC have invited us to do so and I think that, you know, our invitations for SEMAC ... Amy, should set up a conference call ... issue and we can report back in the next meeting, hopefully developed ideas ...

Any further comments on that from anyone?

MR. VAN DER JAGT: Dr. Cooper, this is

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Dr. van der Jagt. There is a question in the chat from Dr. Feuer.

CHAIRMAN COOPER: Yeah, I -- I'm sorry, my computer just knocked -- knocked me out of the -- of the -- of the screen, I'm just checking on that right now.

MR. VAN DER JAGT: Okay. I can just tell you what it is, it -- it's says -- she says, is this suggesting non-transport for peds under this assessment?

CHAIRMAN COOPER: Potentially, yes, I mean, it could, okay. I -- I think that's -- you know, that's part of the whole issue. The whole gist of the protocol was both for adults and children when this was put forward, although clearly ineffective dealing with the adult population because kids weren't getting sick with the Alpha variant at least at the beginning..

The idea was to reduce the burden of, you know, of busy mess in hospital emergency departments and critical care units. And so that would be the, you know, the general idea here is to identify those patients who might not need to be transported.

But then again, you know, our group may feel that -- our group may feel that that's -- that something that isn't right, we may feel that all kids who meet specific criteria, you know, are -- ought to be transport. But I would just not, you know, that's I think for a small group to take a look at.

MR. VAN DER JAGT: I think it is a very difficult thing, potentially because -- for pediatrics, because, you know, you could say you could screen out a certain patient who has come in with isn't a rash, and the family is really concerned about it.

And we've seen many of those kids who come into the E.D. and then turns out to be non-accidental trauma type situation, you know, so it's -- those are the kinds of things that we're going to have to be very careful about that we don't inadvertently, you know, say, you don't have to transport this patient because the complaint seems so minimal.

So I think we would have to struggle with that.

CHAIRMAN COOPER: That's why I think

we need, you know, a small group to look at this in greater detail than we have time for now.

MS. CHIUMENTO: One thing you might --

CHAIRMAN COOPER: Sharon did you want to -- Sharon, go ahead.

MS. CHIUMENTO: Yeah, one thing you might want to do is reach out to Mark Philippy. I just heard on the news last night that here in Rochester, they're actually going to have a nurse -- a sort of nurse triage team are working with nine one one and specifically the City so it would be A.M.R. patients primarily.

So Mark Philippy being their -- their director, or whatever he is these days might have an idea of the algorithm they're using and whether or not they're using it for triaging children as to whether or not they stay home or whether they get transported to a hospital.

So you know, we might just reach out to him and see if he has any input as to what they're using. What those -- what those nurse triage is using.

CHAIRMAN COOPER: Sharon, would you be willing to take on that please?

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MS. CHIUMENTO: I can try to reach him, yes.

CHAIRMAN COOPER: That would be great. Pamela, did you have any additional thoughts?

MS. FEUER: Other than I think there's probably a very small number of kids that shouldn't be transported if they actually call E.M.S. to come to the home. So I would find a protocol very difficult to come up with and be of -- I think of increased risk to kids. So I would like to leave them off of it, you know, under fifteen.

CHAIRMAN COOPER: Fair enough.

MS. FEUER: That's my initial impression, so.

CHAIRMAN COOPER: I will say at least our experience here, you know, the E.R. is deluged with kids who have a -- and have essentially no other symptoms, and maybe a sniffle or something along those lines, and they get tested, they're positive and they get sent home, you know, right away.

And I'm sure that's happening, you know, in other places as well. It doesn't mean that they shouldn't be transported, you know -- you know, necessarily, okay. But I think it's an issue that we

should -- we should discuss.

MS. FEUER: I -- I mean, that is true. The amount of treat and release in most E.R.s is way up right now for COVID. And it could be any other virus. But I think the nuances and especially this period, we -- we talked about croup COVID, there's been a lot more upper respiratory obstruction in younger kids and stuff.

And I think those nuances are tough for any other hospital, you know, team to make an assessment of, so -- you know, and because every kid will have abnormal vital signs of fever, almost every kid so.

CHAIRMAN COOPER: Well, that's why we need to talk about that range and then, you know, and again, they asked us, so I think we should, so we will. Okay. I think I would -- I would think that that was probably the major issue that came out of -- out of SEMAC a week ago.

Amy, please refresh my memory, if you think there's anything that -- else that we need to discuss from SEMAC today?

SECRETARY EISENHAUER: So Mark also mentioned the health -- the health initiative that

they are kind of getting off the ground. And then, of course, he mentioned our discussion of the P.D. Dose, which we already discussed.

CHAIRMAN COOPER: We've already covered that, yeah. That was approved by SEMAC by the way and I think was mentioned earlier. Okay. STAC is not meeting until next week -- not -- I'm sorry, not next week, I think next month at this point, I think I got a note from the Committee was -- was just put off by a few weeks.

So I don't have -- I have nothing, you know, additional to report from STAC. And yeah, I think that -- that was it if I'm not mistaken, Amy, there's no one else right or did I miss something?

SECRETARY EISENHAUER: The Pediatric Trauma sub Committee of STAC so Dr. Prince I guess.

CHAIRMAN COOPER: I don't -- if he's still on, I didn't see him when I looked through the list last time. I think he has dropped off, yeah. And as I say STAC has not met since the last time we met, so -- and they're not meeting for another few weeks.

All right. Well, I think we have completed our -- our published agenda. Is there

anything else anyone wants to bring up at this particular point with -- with the children with emergency conditions in New York State. Hearing none, then I think we are done for the day.

Our -- our next meeting has not been set yet, we're going to set it sometime in March to give us enough time to get any of SEMAC ... SEMAC. Amy will be working on that, I know in the next week or two and so with that I -- we are in a position to give you back some actual minutes of your day.

SECRETARY EISENHAUER: Do we have an adjournment?

CHAIRMAN COOPER: And -- what Amy?

SECRETARY EISENHAUER: A motion for adjournment.

CHAIRMAN COOPER: Yes, of course. We have a motion for adjournment?

MR. CONWAY: I so move.

CHAIRMAN COOPER: Ed Conway, second?

MR. VAN DER JAGT: Second the motion.

CHAIRMAN COOPER: Discussion? All in favor?

MR. BERRY: Aye.

MR. VAN DER JAGT: Aye.

MR. CONWAY: Aye.

CHAIRMAN COOPER: Thank you all very much. Great to see everybody again, I wish everyone a blessed escape from the pandemic as soon as possible. And we'll see all again in March, okay. Thanks again everyone for your participation.

(Off the record 3:48 p.m.)

(The proceeding concluded.)

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STATE OF NEW YORK

I, ANTHONY MCCLAIN, do hereby certify that the foregoing was reported by me, in the cause, at the time and place, as stated in the caption hereto, at Page hereof; that the foregoing typewritten transcription consisting of pages 1 through 124, is a true record of all proceedings had at the hearing.

IN WITNESS WHEREOF, I have hereunto subscribed my name, this the 20th day of January, 2022.

ANTHONY MCCLAIN

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